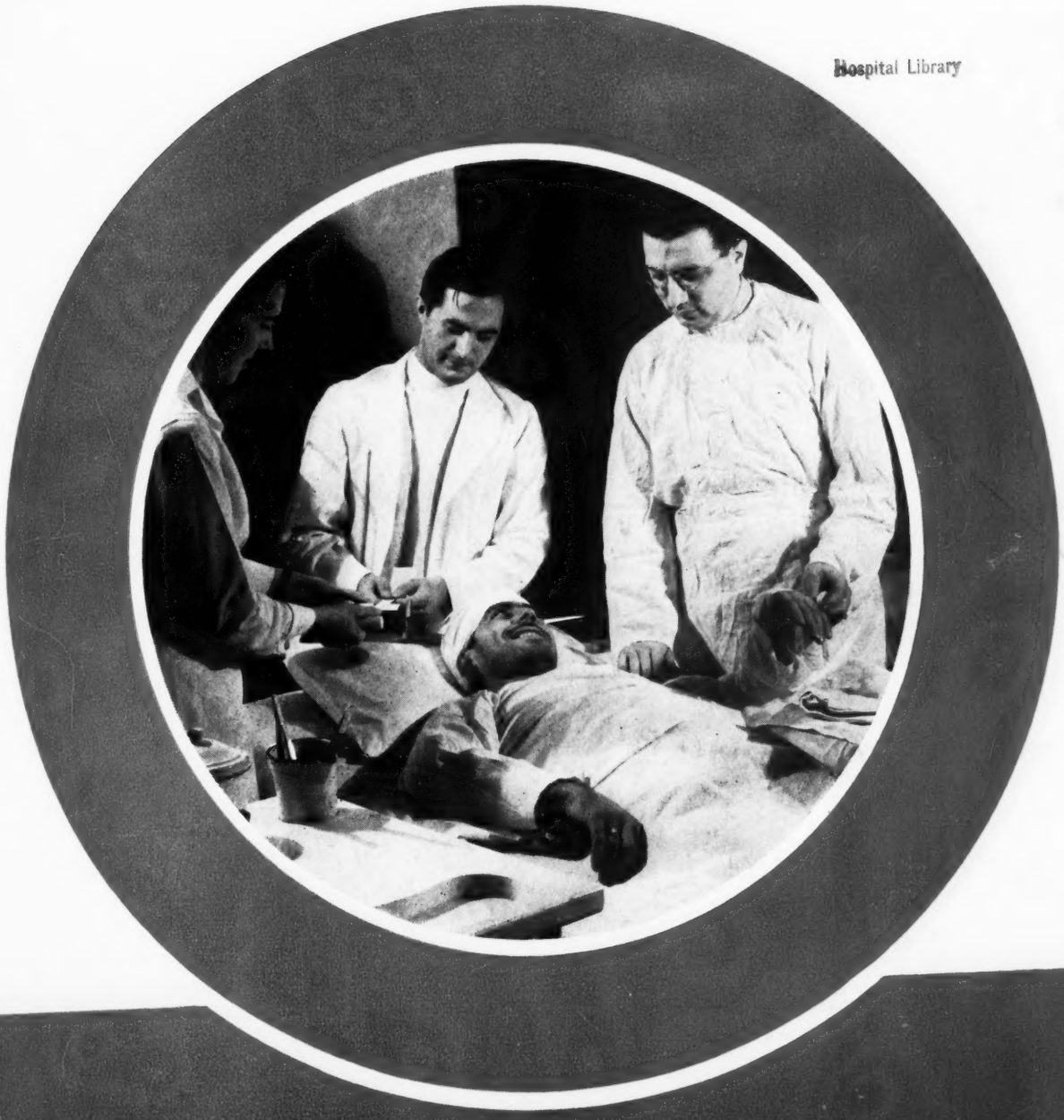
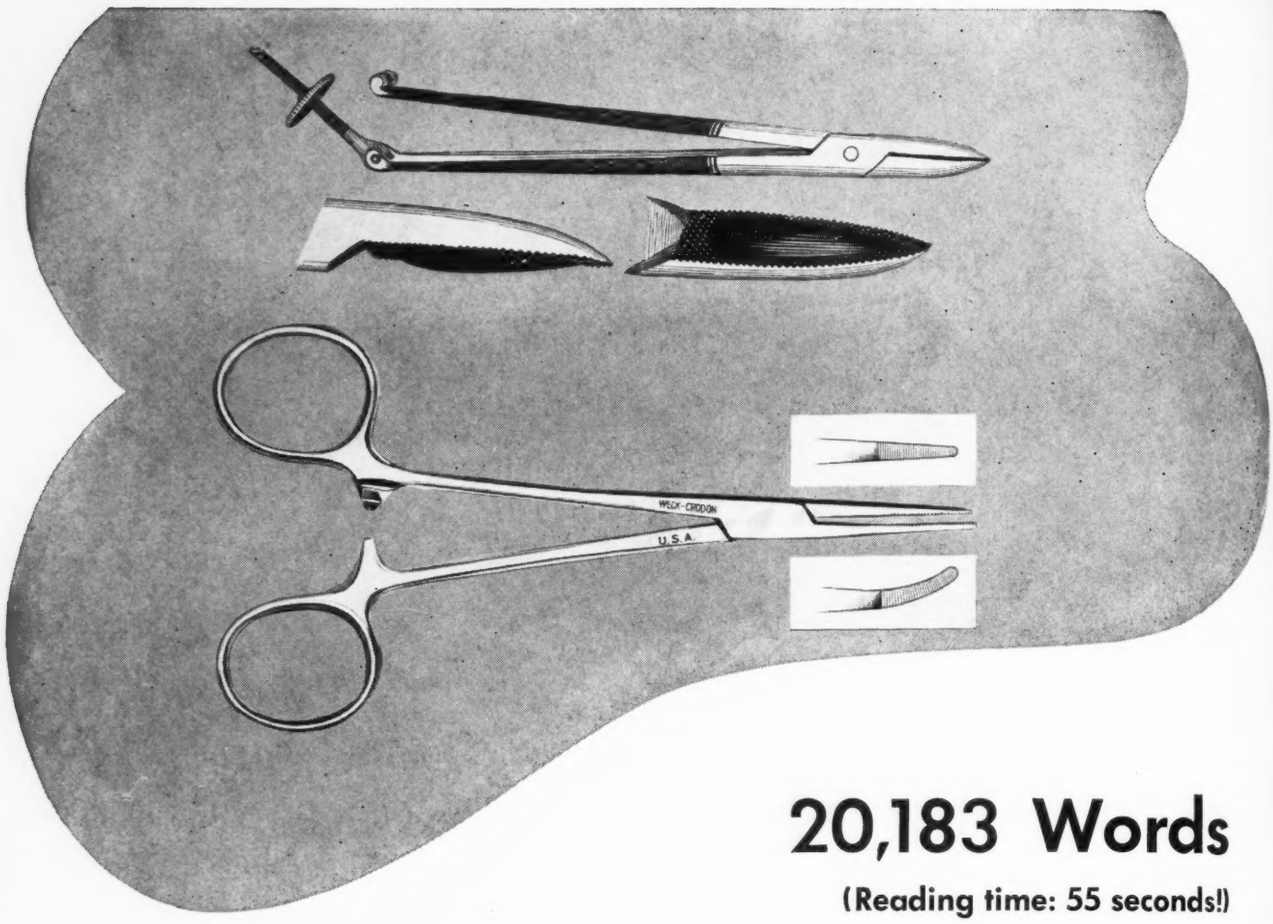


the MODERN HOSPITAL

VOLUME 57 OCTOBER 1941 NUMBER 4



20,183 Words

(Reading time: 55 seconds!)

THE CHINESE have a proverb: "One picture is worth 10,000 words."

On that basis, this advertisement has 20,183 words — the first 20,000 words, however will be found in the two contrasting pictures above.

At the very top is an UNRETOUCHED reproduction from a hospital instrument catalogue issued about the year Weck began business — 1890 — which calls this enormous device "Nott's Artery Clamp Forceps," and says "useful for closing divided vessels by clamping, constriction and ateriversion."

Contrast that cumbersome old-timer with the modern Weck-made MAYO-KELLY Haemostat, likewise pictured unretouched immediately below. But you must see and handle the Weck instrument to appreciate its box lock, its graceful yet positive jaws.

This Weck-made instrument is typical of the Weck line now available. Made in stainless steel, or Crodon Chrome-plated — as preferred. In stock, ready for immediate shipment, guaranteed by Weck 100% American-made, order a gross or a trial dozen, with complete confidence.

Backed by the 50-year old firm of Weck; now and always insist on Weck-made instruments. Weck's "four surgeons" stand for WORKMANSHIP, ECONOMY, CONFIDENCE, and QUALITY.

Founded 1890

Edward Weck & Co., Inc.

Manufacturers Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street — Brooklyn, N.Y.

CONTENTS

For October 1941

Just in Passing—

THE CARE of the patient who, during his hospital stay, develops a mild psychosis has become a real problem in the general hospital. In the November issue Dr. Maxwell S. Frank will tell how the situation has been met and solved at Mount Sinai Hospital, New York City.

YOU ARE invited to inspect the new building of Nassau Hospital, Mineola, L.I., N. Y., in the pages of The Modern Hospital next month.

THE THIRD in Dr. Morris Hinenburg's series of articles on the administrator's calendar will be published in the magazine next month. This article deals with the administrator's seasonal duties during the winter months of December, January and February.

IF YOUR hospital, like so many others, has been called upon to treat a greatly increased number of head injury cases, you will be interested in reading what Dr. Ernest Sachs and Dr. Frank R. Bradley have to say on the subject in an article that will appear in November.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
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Return to .....

The Modern Hospital

EDITORIAL BOARD

EDITORIAL CONSULTANTS

Published monthly and copyrighted, 1941, by The Modern Hospital Publishing Company, Inc., 919 N. Michigan, Chicago. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; J. G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U. S. A.

After the Baby Comes

After the disagreeable events of childbirth have been left behind the delivery room door, the new mother longs for home. She anticipates with pleasure the complicated schedules, broken sleep, new worries and cares that will replace her previously well-ordered existence. All these will be minimized by the joys of motherhood. She wants to go home.

Recovery during the postpartum period often can be hastened with 'Ergotrate' (Ergonovine Maleate, Lilly) or 'Ergotrate H' (Ergonovine Hydracrylate, Lilly). Involution is accelerated and there is less danger of hemorrhage or infection when the uterus is held in a constant state of contraction. The administration of 'Ergotrate' or 'Ergotrate H' is now a routine procedure in many hospitals.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

For Better Social Service

• Should you happen in at Peter Bent Brigham Hospital, Boston, on just the right day and just the right hour, you'll find medical social service rounds in progress. These were started a year ago at the request of the medical service and have proved successful in integrating the work of the two departments, Dr. Norbert A. Wilhelm, administrator, tells us.

Rounds take place regularly at an appointed time on each medical ward. Those participating are the junior assistant resident and the medical social case worker assigned to that ward; also the interns, who are urged to attend, and the head medical resident and the director of social service who are directly responsible. The meetings are conducted in the presence of the patient as it is thought advisable for him to be aware of the social and emotional factors in his illness and for him to see and accept the medical social worker as part of the medical team.

The junior assistant resident is responsible for conducting the rounds and discusses briefly the medical and social situation, the relationship of one to the other and the patient's ability to meet his problem himself. If the doctor believes that the patient or patient group needs the assistance of the medical social worker in carrying out adequate treatment or if the doctor desires a more adequate study of the patient and his environment to assist him in diagnosis, the patient is referred to the social service department. Little time is spent with those patients who present no apparent medical social problem. This has been thought advisable because of limited staff time, the time consumed in reviewing each situation as adequately as the next and the recognition that one may do as good a teaching job with a limited number of situations.

"These rounds have a threefold purpose," Doctor Wilhelm explains. "First, they provide a means whereby the social service department gets referrals from the medical service at an early date and in an organized fashion. Second, they foster joint thinking and discussion by the doctor and the medical social case worker, thereby integrating more closely the work of the two departments. Third, the rounds provide one method of teaching house officers the social aspects of medicine in order to create an awareness of the social component in medical care that will better enable them to recognize and deal with this in private practice where the services of a trained medical social worker are not available.

"The success of medical social rounds," Doctor Wilhelm continues, "depends first on the doctor's interest in clinical medicine rather than in research and, second, on the contribution that the medical social worker can make from her experience and knowledge in the broader social aspects of a situation. It is important that the rounds not become stereotyped and deal merely with specific situations, but rather that discussion of generic concepts be stimulated."

Incidentally, a trip to Peter Bent Brigham is not complete without seeing the offices that are provided for the physician-in-chief, the surgeon-in-chief and five other physicians holding senior appointments in medicine and surgery.

"It is our belief," Doctor Wilhelm will tell you, "that this contributes to the better care of ward patients, since these men, through having their offices here, are available at all times and may be called upon at any hour for consultation."

Deposits on Babies

• Sutter Maternity Hospital in Sacramento, Calif., runs a Stork Savings Bank with a specially designed bank book for listing deposits. On its cover is Mrs. Stork, ensconced comfortably on a luxuriant nest, her partner standing proudly alongside. R. D. Brisbane, administrator, does not boast about the artistry.

Cover design for stork bank book wherein deposits for future hospitalization are listed.

"No one seems to see the stork here," he confesses, "because he flies at night most of the time, which may account for any lack of proper anatomical proportions." It isn't the authenticity of the design that matters, however, as much as the deposits listed within, and also the story of the hospital told briefly on the back cover.

Advance collections amount to more than $1000 with less than $100 outstanding, a record, unquestionably. "Even a dishwasher at one of the hotels saved a small amount weekly to give his wife and baby a proper start," Mr. Brisbane tells us. "And only recently one woman came in and placed a $100 deposit on her third baby since the hospital was opened in November 1937."

At Sutter Maternity Hospital there are no less than eight nurseries with seven babies in each, and patients have to be turned away! This accounts for a building program that will provide 20 additional beds in another wing as well as a premature nursery.

N.Y.A. Supplies Aids

• Recently, when your Roving Reporter stopped in at Huntington Hospital, Huntington, N. Y., to chat for a few minutes with Mary Hutchinson, he was impressed with the number of attractive young women engaged in various duties about the hospital. Apparently, Miss Hutchinson was experiencing little or no difficulty getting nonprofessional workers. She confirmed this impression and proceeded to tell of her success with the National Youth Administration project that has placed at her disposal groups of young people of the community.

Today, 30 girls from 18 to 25 years are doing all sorts of work about the hospital and doing it well. When the project was started in 1937 they were assigned principally to the housekeeping and dietary departments where they still get their basic training. Today, however, they are serving in nonprofessional capacities in the laboratory, nursing, x-ray and other departments. The scope of their work has steadily increased as they have demonstrated their value.

The term of training is eighteen months, during which time they receive $22 a month from the government for sixty-six hours of labor. At the expiration of that period they must find employment in the hospital or elsewhere. At least 25 per cent of those who have entered have been employed regularly by the hospital. They wear the same uniform as other nonprofessional workers in the department to which they are assigned and are made to feel they are a part of the employe group. Some have become so interested in their work that they are continuing their studies to attain professional rank.

STILBESTROL was described and named in 1938 by Dodds, Golberg, Lawson and Robinson[1] who reported that it was "by far the most potent" of the many synthetic estrogens investigated. Since that time the product has undergone extensive clinical trial and more than one hundred papers have been published reporting its uses and advantages. Stilbestrol Squibb was used in a large number of these studies.

Stilbestrol Squibb (alpha, alpha'-diethyl-4, 4'-stilbenediol) is a synthetic estrogen for replacement therapy in deficiency of the estrogenic hormone. In contrast to the natural estrogens it is only slightly less effective orally than intramuscularly. Stilbestrol is also much more economical to use and therefore its field of usefulness is greatly enlarged

The use of Stilbestrol has been established in alleviating vasomotor symptoms of the menopause (both natural and surgical); gonorrheal vaginitis in children; senile vaginitis and kraurosis vulvae and pruritis vulvae of the menopause. It may be administered orally, hypodermically, or intravaginally. Dosage and route of administration vary with the condition being treated and with the individual patient. In common with other highly potent chemotherapeutic agents, Stilbestrol should be used with caution and only under the immediate supervision of the physician.

[1] Dodds, E. C.; Golberg, L.; Lawson, W.; and Robinson, R.: *Nature* 141: 247, 1938.

How Supplied: Stilbestrol Squibb is supplied in three forms:

COMPRESSED TABLETS, either uncoated or enteric-coated (*for oral administration*) containing 0.1 mg., 0.5 mg., 1.0 mg., 5.0 mg. in bottles of 25, 100 and 250.

AMPULS (*for intramuscular injection*) in 1-cc. ampuls containing 0.2 mg., 0.5 mg., 1.0 mg. and 5.0 mg. per 1 cc. respectively, in boxes of 6, 25 and 50.

PESSARIES (*for vaginal medication*) in two sizes. 0.1 mg. for children and 0.5 mg. for adults, both in boxes of 12 and 50.

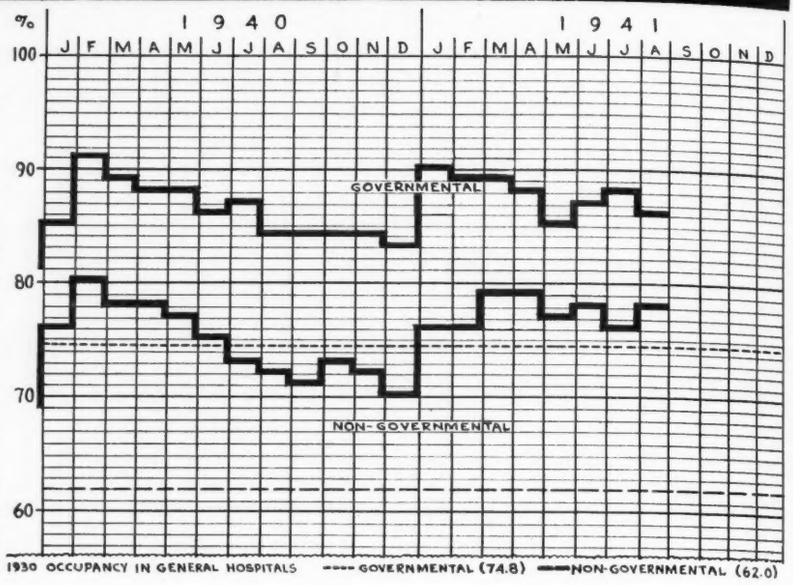
For literature write Professional Service Dept., 745 Fifth Ave., New York

E·R·SQUIBB & SONS, NEW YORK
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1941: Aug.	1941: July	1940: Aug.	1940: July
Governmental:						
New York City	17	10,380	95*	95	94	101
New Jersey	5	2,136	92*	92*	82	100
N. and S. Carolina	20	2,655	77*	76	73	74
New Orleans	2	2,800	77*	78*	83	81
San Francisco	3	2,255	107*	114	95	95
St. Paul	1	850	64*	64	69	67
Chicago	2	3,500	85*	84*	88	90
Total[4]	50	24,576	85*	86*	84	87
Nongovernmental:						
New York City[3]	70	16,526	77*	77*	66	72
New Jersey	56	8,111	79*	79*	68	67
N. & S. Carolina	109	7,913	68*	68	67	67
New Orleans	6	1,233	85*	83*	82	84
San Francisco	16	3,178	81*	80	74	73
St. Paul	9	1,134	78*	78	72	74
Chicago	28	5,870	73*	76	67	70
Cleveland	15	3,085	83*	82	81	82
Total[4]	309	47,050	78*	78*	72	73

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



August Occupancy Continues High; Sharp Rise in Commodity Prices

Occupancy in both governmental and nongovernmental hospitals for August remained almost stationary, according to preliminary figures, 85 per cent occupancy being reported for governmental institutions and 78 per cent, for nongovernmental.

The latter figure represents a large jump over the August figure for last year, which was 72 per cent.

The slight decline of 3 points in occupancy in Chicago nongovernmental hospitals was equalized by a 3 point gain in New Orleans institutions.

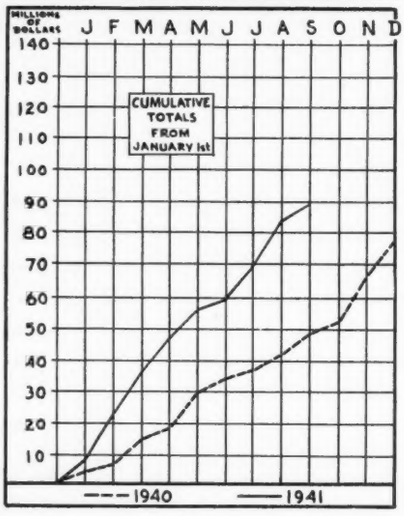
Construction figures reported for the period of August 11 to September 8 show 51 hospital projects, 45 of which report construction costs totaling $6,241,201, or less than half the total construction figure reported last month. A breakdown of this total reveals: 17 new hospitals and allied institutions, of which 13 report costs totaling $1,243,300; 28 additions to hospitals are recorded, of which 24 report $4,711,601 total costs; seven alteration projects have a total of $237,300, and one nurses' home is estimated at $50,000. The cumulative total for this year's hospital construction to date is $88,890,973 as compared with $48,733,926 for the same period in 1940.

In spite of the foregoing figures, a summary just released by the United States Census Bureau calls for 2000 more hospitals averaging 170 beds in the United States. Complete details of the release may be found in our news columns. A number of construction projects in defense centers are on the President's desk for approval.

Commodity Price Comparisons

Commodity	August 16	Sept. 12
General Wholesale Prices	93.5	95.8
Grain	81.5	88.1
Food	87.8	92.1
Textiles	94.9	96.8
Fuel	96.1	96.7
Building Materials	114.5	117.3
Drugs, Fine Chemicals	221.8	222.9

HOSPITAL CONSTRUCTION



The general price index of the *New York Journal of Commerce* for the period August 16 to September 12 shows appreciable advances. Grain rose steadily, week by week, from 81.5 in the former period to 88.1 on September 12; textiles advanced 1.9 points, and food prices rose from 87.7 to 92.1. Fuel showed the least range, with only a 0.6 advance over last month's figure. Building materials, however, dropping from 114.5 on August 16 to 113.3 on September 5, climbed sharply to 117.3 on September 12. This index represents an all time high for the price of building material since the *Journal's* figures were first recorded in these columns in 1933. The only periods when the index figure for building materials (based on 1927-1929 prices as equaling 100 per cent) approached the present quotation were during the weeks of October 19 and October 26, 1940, when the figure stood at 117.1.

Oil, Paint and Drug Reporter's price index of drugs and fine chemicals records a fluctuation of 1.1 between August 18 and September 15. On the former date the quotation stood at 221.8 and on September 15 it was 222.9. These percentages are based on the price index of 100 as of Aug. 1, 1914.

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For restful sleep and relaxation . . . Give patients INDIVIDUAL QUIET* at the time they need it most

***Individual Quiet**—Quiet when the patient *needs it most.* Even in the midst of the most disturbing noises, peaceful nerve-soothing quiet is always at your patient's call—with Flents. *Invaluable to shut out noises of patients and visitors in open wards which may disturb other patients.*

Physicians agree—quiet and peace induce rest which helps recovery. Day or night Flents give patients the comfort and relaxation they need. No fuss, no bother, no drugs. Superintendents welcome Flents for three important reasons:

1. Flents are economical. They assure patients of quiet without expensive building alterations. *Nominal cost per patient.*

2. Flents are safe. Recommended by physicians for 15 years. Flents are soft, hygienic, pliable balls of wax and cotton. Merely place in ear; instantly removable.

3. Flents protect the patient from disagreeable noises of other patients which may retard recovery.

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DOCTORS—NURSES, TOO!

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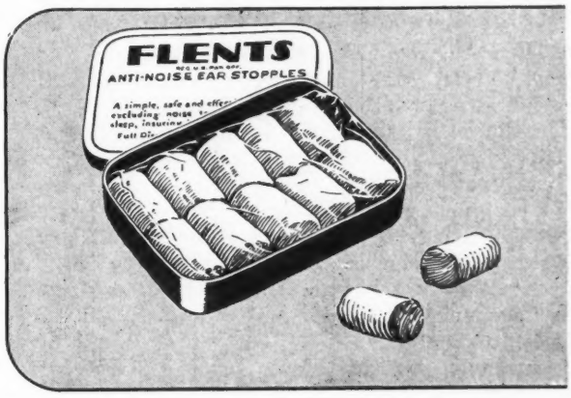

FREE: *Adequate supply of samples of Flents Anti-Noise Ear Stopples to test in your hospital. Just mail coupon.*

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MH-3

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Please send free supply of samples of Flents Anti-Noise Ear Stopples and full information for hospital use.

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Hospital_____
Address_____
City_____ State_____

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky., Alloys F. Branton, M. D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Computing the Hospital Day

Question: When does the hospital day begin? We have been using the hour of admission for the beginning of the day, any part of a day after the hour of admission being considered a whole day. Are we correct in this procedure? If not, how do other small hospitals handle the situation?—J.B.D., Ga.

ANSWER: There are two general classifications of hospital days: statistical and financial. According to the statistical patient day reckoning each day, fraction of or entire, closes at midnight. Census, earning and cash receipts are computed and posted for the day closing. This is approved statistical and accounting procedure.

The financial patient day actually terminates on the hour of admission. Rarely is there a day of dismissal on which the patient leaves on the exact admission hour. Many hospitals have adopted the following policies of charge:

One to eight hours, ¼ room charge; eight to sixteen hours, ½ room charge; sixteen to twenty-eight hours, full day charge. Checking out periods for half day and full day rates are conducted on a plan as acceptable and satisfactory as hotel precedent of charge.

Do not be too "clockish" when invoicing day charges; the favor of a few hours' free service to the patient is good advertising at the bridge table.—GLADYS BRANDT.

Dietitian Preferred

Question: Is it advisable for a small hospital to have a full-time dietitian?—L.G.T., Mich.

ANSWER: I can think of no better answer to the foregoing question than the following quotation taken from page 470 of "Hospital Organization and Management," by Dr. M. T. MacEachern.

"Successful performance of these manifold duties [of the dietitian, namely, administrative, scientific and educational] obviously requires the services of a competent graduate dietitian. However, there may be a few hospitals of less than 50 beds which, because of their size, may not consider themselves justified in employing an especially trained woman.

"Inasmuch as food service involves approximately one third of the total expenditure of the hospital, this is a serious problem and the hospital that cannot afford to employ a dietitian is under a distinct economic and therapeutic handicap. In such an institution, the responsibility for the food service will be entrusted to the director of the hospital, the director of nurses or one of the other department heads who is interested and who has had some training and experience in the work. Occasionally, it is feasible to combine the housekeeping and dietary departments in the small hospital, provided the housekeeper has a knowledge of dietetics, or vice versa. In the absence of a competent dietitian it is incumbent upon the attending physician to be responsible for the details of diet therapy."—DONALD M. ROSENBERGER.

Avoiding Loss on Insurance Patients

Question: How do you avoid taking care of insurance patients at a loss?—O.M.G., Wis.

ANSWER: The answer to such a question lies chiefly in being thoroughly familiar with the state law. These laws vary from state to state and from year to year.

A common failing of these laws is the inclusion of a set and arbitrary limit of each type of case, which, if the hospital were to break even, would provide only the poorest of service. There is a clause in the compensation bill in several states stating that the amount should be limited to that usually paid in the community for the same grade of care.

The hospital itself may well establish strict rules for its own protection even when the state laws appear to protect it. The first suggestion for internal protection lies in getting a statement in writing as to who is responsible for the debt. An assignment of claim should be obtained, if possible, for then it is impossible for the insurance company to settle with the patient and leave the hospital out of it. A lien should be filed in states in which a hospital lien law is in effect.

The administration of first aid should never mean admission to the hospital. The hospital is bound to give first aid but then its duty is done and service should stop there until either an official of the company, if it is an industrial case, or other responsible person signs for the financial obligation of admitting the patient to the hospital. Under the workmen's compensation laws the employer is responsible for the medical expenses of his employes when injuries or illness arise out of their occupation; therefore, the employer's duty goes much further than the hospital's.

Some hospitals protect themselves by having a rigid rule to the effect that only a member of the regular attending staff may treat patients in the public wards. This means that the insurance doctor and the insurance company lose control of the patient unless they sign papers for removal to a semiprivate room at a higher cost than the ward rate. For instance, an accident patient is brought into a hospital, given first aid and placed in a ward before the insurance company's representative or the patient's friends arrive. When the request for the insurance company's doctor or the patient's family doctor is made, it can be made clear to all concerned that if the care is to be given by an outside doctor removal from the ward is necessary. Removal may not be done until some one signs the papers to establish the credit and, therefore, assumes the responsibility of the debt. Thus the hospital is protected.

There are many more methods for use in specific cases, but since the question is so general space does not permit their discussion.—DON C. HAWKINS.

How Many Nurses?

Question: How many general duty nurses, including the delivery room supervisor, should be required for a hospital of 30 beds when the nurses have to take care of the delivery rooms? —B.L.K., Mich.

ANSWER: A basic staff of eight nurses should be able to handle the situation. I take it that the 30 bed hospital runs at 75 per cent occupancy in giving my answer.—ALLOYS F. BRANTON, M.D.

For Painting Walls

Question: What paint and finish are best for hospital rooms? The flat finish we are using is unsatisfactory.—H.N., Iowa.

ANSWER: A flat finish will entail problems in cleaning. For this reason, a low-sheen paint, one having a semi-gloss, is preferable. In purchasing paint, the best quality available will prove most economical in the long run. The large manufacturers maintain service departments from which charts, color swatches and other helpful information are available.

In planning the color scheme some consideration should be given to ceiling treatment. If the ceiling is high, it can be brought down by using darker shades. Otherwise, an interesting effect can be gained by employing either a tint of the wall covering or a contrasting color.—RAYMOND P. SLOAN.

LOOKING FORWARD

Tax Exemption for Hospitals

THE tax exemption accorded to voluntary hospitals is a badge of the prestige and affectionate regard which they are accorded by the general public. Furthermore, it is an important monetary asset, especially now when taxes are rising.

The decision recently rendered by a referee in the case of the Doctors Hospital of New York City, therefore, carries significance to all hospitals that enjoy tax exemption. Although the referee found that the Doctors Hospital had been properly incorporated as a nonprofit institution and that there was no "taint" on the hospital because its trustees also had been directors of the 87th Street and East End Avenue Corporation (which originally built the institution and leased it to the hospital on a profitable basis), he could not find enough truly charitable activity on the part of the hospital to justify a tax exemption.

"Not only in the state of New York but throughout the country there are any number of decisions on the question of exemption from taxation. The basis of the grant of exemption is always found to be built upon charitable work for the general public and to an extent that would justify an exemption. However, the amount of the charitable work done must have some relation to the amount of taxes that are exempted. Furthermore, the nature of the charitable work must be definitely for the benefit of the general public who cannot afford to use the hospital and pay the charges of a physician, as well as those of the hospital.

"Doctors Hospital, Inc., was undoubtedly originally formed with the idea that it was to be a private hospital and was to be run only for the benefit of the doctors who were members of the hospital. It was not contemplated that the public should have a right to use the hospital. However, when they dispensed with the stock corporation that was to finance the Doctors Hospital, Inc., and transferred all of the assets of the stock corporation to the Doctors Hospital, Inc., a membership corporation, they were in a position to establish a clinic, dispensary, ambulance or any other feature that would open the doors to the general public, irrespective of race, creed or color. Not until 1935 did they establish the so-called free service in setting aside 10 beds that could be used only by the doctors of the hospital and not by the general public. The so-called charity that the Doctors Hospital, Inc., now claims it is doing can scarcely be said to be a *quid pro quo* for the substantial sum of $65,000 annually, the amount of the tax imposed upon its property."

Other hospitals enjoying tax exemption might well examine their policies critically to see if the amount of their charitable service is at least equal to their taxes and whether this service is generally available to the public or is restricted to the clients of a small fraction of the medical profession.

A "Significant Contribution"

IT IS with great pleasure, indeed, that The MODERN HOSPITAL is able to announce in the convention report section of this issue that the first Modern Hospital Award, with its accompanying certificate and gold medal, is to be conferred upon Lucius W. Johnson, Captain, Medical Corps, U. S. Navy. Captain Johnson's prize-winning article, entitled "We Are Already Late in Our Preparations for Aerial Bombardment," appeared in our December 1940 issue.

The certificate of award reads as follows: "This is to certify that The Modern Hospital Award and Gold Medal has been conferred upon Lucius W. Johnson, M.D., for presentation in print of a significant contribution to the advancement of hospital administration and hospital service." Details regarding the basis of the award were published in the October 1940 issue of the magazine.

The committee of judges considered carefully a very large number of articles before reaching a decision. It was not entirely easy to pick one from so many.

Since the award was established "to encourage the development of new ideas and technics in hospital administration, to improve the quality of hospital literature and to recognize individual and group achievement," any person engaged in or interested in any aspect of hospital work (unless employed by The MODERN HOSPITAL or a member of its editorial board) is invited to submit original manuscripts. Upon pub-

lication, they are automatically entered in the contest. The second year of the contest started with the July 1941 issue and will run through June 1942. Articles are judged primarily upon the value of the ideas embodied and then upon originality, practicality and wideness of application.

It is, perhaps, an indication of the increasingly close cooperation that is developing between the voluntary and the governmental hospitals that this first award is won by a man who has devoted his life to medical service in the U. S. Navy, yet who writes on a subject of direct concern to civilian hospitals. The Navy Department and the hospital field are both to be congratulated upon having such a fine liaison officer in Captain Johnson.

Hospital Coordination

AS WAS pointed out by Mr. Speller in his London letter that appeared in our July issue, the hospitals of England are even now hard at work on postwar plans for better coordination of their services. In this fact we can learn an important lesson.

It is time that we hospital people, particularly those of us who are directly concerned with the voluntary hospitals, realize that we cannot forever continue to play the "lone wolf" game. We must learn to work together effectively with the greatest economy and without unnecessary overlapping or duplication of effort in order to assure the community of the best possible service which the community's hospital dollars can buy.

Dr. Malcolm T. MacEachern, who has been following the developments in England closely and who has long advocated closer cooperation among hospitals in the United States and Canada, recently wrote:

"Surely in America we must have the same spirit (as that now manifest in England) in our hospital preparedness program. We, too, need regionalization and coordination between public and voluntary hospitals. Adopting the theory of utilizing existing organizations, we might well work for greater cohesion among local hospital councils, which together could form a representative group in the state hospital associations. The regional assemblies could form the next geographic division, with further coordination through the American Hospital Association.

"Study committees to present plans for better distribution and regionalization of hospital facilities could be appointed in each community that has a council, in each state and in each region. Here, as in England, hospitals have been established haphazardly in many communities. The emergency program is taxing the facilities of hospitals in many other communities which before were amply served by their hospitals.

"There is need for planning and replanning on a correlated basis to strengthen our hospital defenses now and for the future."

The hospitals of Great Britain were given a blueprint for future action, first in the Cave report in 1921 and then in the report of the Sankey commission, published in April 1937. This blueprint has now some "power of the purse" behind it, owing to the establishment of the Nuffield trust.

Perhaps the time has come when a similar blueprint might well be drawn for the hospitals in this country. A commission of distinguished leaders in public health, philanthropy, education and hospital administration (representing both the voluntary and the governmental hospitals) might well be set up at the instigation of the American Hospital Association to make a thorough study of all aspects of this broad problem and to bring in recommendations that could command the attention and, it would be hoped, the support of all concerned.

Obviously, in any such coordinative effort, rigid uniformity, regimentation, excessive regulation and unnecessary control should be avoided. There must be much elasticity of detail. On the other hand, it is becoming increasingly clear that if we do not want the government to take over effective control of our voluntary hospital system, we must do the job ourselves.

Directing Volunteer Efforts

A REVIEW of the increasingly important contributions that women's volunteer groups are making to hospitals everywhere reveals some significant trends, not the least of which is the evidence of better planning and sounder organization. The services of a paid volunteer secretary, while not within the scope of some institutions, is being approximated in many hospitals by public-spirited women who are giving much or all of their available time to supervising this work which is daily assuming greater proportions. As the benefits of competent leadership are realized it is to be hoped that professional guidance will be made possible to a greater degree through funds raised for this particular purpose.

Professional assistance as a panacea to many of the ills of which amateur endeavor falls heir is just as efficacious when applied to specific projects as it is to general organization. What hope is there for the coffee shop that is operated by someone unfamiliar with food service, the gift shop whose head has no merchandising background or the furnishings plan conceived not by one but by a group of enthusiastic amateur decorators possessed of little knowledge of hospital requirements?

That the success of volunteer enterprise rests not alone with the monies raised and the individual effort applied but also with the disposition of such sums and the direction of personal effort to the greatest benefit of the hospital is being demonstrated daily. In such times as these this fact stands as something on which to hang hope for the future.

High Turnover of Personnel

What Can We Do About It?

JOSEPH C. DOANE, M.D.

FOR the last several months hospital administrators have observed increasingly unsettled conditions in the institutional labor situation. The causes for this condition are not uniform in all localities but it may be said that, generally speaking, all relate to the defense effort being prosecuted in this country. These causes may be set down as follows without any attempt at evaluating their importance or frequency by the order in which they are named.

1. The will-o'-the-wisp of higher wages offered in defense plants of all types.
2. The laudable lure of national service and the result of the functioning of the Selective Service Act.
3. A definite seasonal effect.
4. The general uncertainty of the times.

Each of these causes possesses its individual lure to certain types and classes of hospital employes. Each, moreover, has its proper and improper method of handling. All act to produce the same effects on the hospital: (1) an increasing pressure for higher wages; (2) the loss of highly trained key personnel and a gradual decline in the quality and the timbre of those now filling such positions; (3) the necessity for combining positions and replacing trained workers by those less well prepared but under closer supervision; (4) the closing of some departments entirely, and (5) the difficulty of satisfying a critical public that continues to demand perfect hospital service irrespective of the stress under which the hospital is laboring under present day shortages.

It can be taken for granted that a community charitable activity, such as the hospital, cannot compete with the wage scales now offered in industry or with those now in effect in defense plants or in their adjuncts, such as cafeterias, social service organizations and like pursuits. The hospital is defeated before it begins in an economic combat of this particular variety.

It is a common thing, for example, for an elevator operator who receives $60 a month to obtain a position in industry paying almost as much a week. To be sure, such a hospital employe may have received maintenance in addition to his salary and may have been a resident in the institution for many years. But the temptation inherent in the possibility of doubling, tripling or even quadrupling his visible income is not easily resisted and the hospital, on short notice, is required to replace a well-trained and an efficient worker.

The major problem distressing hospital administrators today is the flux of personnel. Doctor Doane analyzes its causes and the possible solutions. He counsels equanimity

A social worker receiving $1200 per annum is often able now to obtain 50 per cent more salary in a governmental bureau. Dietitians, engineers, orderlies, kitchen workers and, of greater importance, nurses and physicians are departing by the score to obtain more lucrative employment elsewhere.

Perhaps the greatest percentage of turnover has been among cooks, kitchen workers, orderlies and power house and laundry workers. Chefs and their assistants have been particularly fugitive and the bidding for their services by hospitals has been keen.

The expected seasonal effect on workers of this class has been aggravated this year by the fact that, with no travel abroad, seashore and mountain resorts have been flourishing as never before. Wages there have been high and hospital workers, relying on the assurance that they will be received with open arms when fall comes, have deserted by the dozen. This seasonal migration has served only to intensify the dearth of steady hospital labor, which has been in evidence since the year began.

The lure of patriotic service has not affected the young men of the community alone. Fortunately for the government but unfortunately for the hospital, many of the best graduate nurses have left their community and institutional activities and have entered Army and Navy service.

Many of the younger men of the clerical, technical and semimedical types are numbered among the nation's selectees. Other activities, such as medical and nursing service abroad on a voluntary basis, have attracted some physicians, nurses and other members of the hospital personnel.

Intern staffs have been so depleted that embarrassment of medical service has resulted. Particularly in those institutions relying entirely upon a paid resident medical staff has the care of patients been carried on with great difficulty. This situation is aggravated in many communities in which practicing physicians have volunteered their services to the government and are now in military camps or on the sea.

There exists, moreover, a general social unrest which has set workers of all types to wondering what the future holds for them. This frame of mind is not conducive to the highest degree of efficiency and adds measurably to disciplinary difficulties in the hospital.

As to the effects, one of the chief difficulties now facing every administrator is the almost daily pressure to meet an ever climbing pay roll. After each pay day lower bracket help fails to return to duty in alarming numbers. The executive debates whether he can check this flood of departures by raising salaries or by discussing future possibilities for hos-

pital advancement. If the former is decided upon, he is much in doubt as to whether salary increases will have any permanent effect and whether they should be made on an individual basis or whether some general policy should be adopted covering all members of a class. The executive certainly must realize the danger of precipitating further difficulty by adding to the recompense of one of a group only. How to handle such requests is a current and vital administrative problem.

A sequel or, perhaps, a corollary of the first named effect is a downward slide in personnel efficiency. Indeed, there is a definite deterioration in the physical status of hospital workers. Is it proper and safe to engage workers afflicted with chronic hernia, advanced varicosities of the veins of the extremities, obesity or chronic cardiac defects in order to keep the wheels of the hospital turning?

These individuals, unfit for military or industrial service, are available for hospital work. Among this group frequently are found faithful, capable and efficient workers. Some method must be originated to keep down compensation rates if such persons are employed because the expense to the hospital for carrying compensation varies with the number of accidents and illnesses that are considered compensable.

The downward slide in mental effectiveness is another real problem. This may be met, perhaps, by maintaining at all costs highly efficient supervision.

New plans, of necessity, have been made to meet some of these disturbing personnel problems. Women have been substituted for men whenever possible. Positions have been combined. In some instances, the housekeeper has taken over the supervision of the laundry and skilled graduate nurses supervise an ever growing number of nurses' aids. Although state labor laws generally allow fewer hours for work for women than for men, with added requirements for rest rooms and health examinations, some institutions have found it necessary to substitute females for male chefs, waitresses for waiters, women for men as elevator operators and even have endeavored to obtain women physicians in increasing numbers to replace men who would be likely to be drawn for military service. The closing of departments has been left as a last defensive move.

Occupational therapy, physical therapy and, occasionally, social service departments have felt the pinch of the present shortage of help. On the other hand, all of these activities can ill be spared because of an ever-increasing community demand and because the occupancy of private and ward beds is increasing almost everywhere.

The difficulty of informing the public of present day hospital problems without implying an apology for existing defects is not easy to overcome. The public demands perfection but is not always willing to pay for it. Certainly, it is not wise habitually to excuse mistakes because the personnel is less efficient and plenteous, even though this situation is not of the hospital's making and often is impossible of solution.

The members of the board of trustees and the administrator are urged to keep their individual and collective heads. Equanimity, coolness and a total absence of a distracted running to and fro are likely to be reflected by a calm mental attitude in hospital workers of all types. No one is essential to the hospital organization.

The raising of wages should be done by classes, as a rule, and not by individuals. Wage scales should not be increased without some idea of the source of the money to meet them. No board of directors in an industry observing a rise in the cost of manufacture of an article would be content to continue to sell it at a loss. Raises should be consonant with the practice of other hospitals in the community.

The next step is to search for a legitimate way by which the public may be asked to meet this increase in hospital cost. The mistakes made in 1918 should not be repeated in 1941. In the former year increasing costs gave rise to huge deficits and, usually, no attempt was made to meet this added expense before the annual deficiency had occurred. Whether this projected increase in costs will be met by a flat increase in room rates or by some other legitimate means is a matter for the hospital's own decision. The point to be stressed here is that it is not good business to incur a deficit and then become frightened. Now is the time to increase income proportionately so that the new costs may be met.

Finally, no patriotic hospital board and no administrator will place obstructions in the way of the defense machine as it gathers momentum. They will not endeavor to entice valuable workers from government and defense services. However, they will expect the aid of government and industry in maintaining what, after all, is as important a public utility as any in existence.

Labor Turnover in One Eastern Hospital, Showing Length of Employment and Cause for Leaving

	Less Than 2 Weeks		*2 Weeks to 3 Months*		*3 Months and Over*		*Per Cent*
	M	*F*	*M*	*F*	*M*	*F*	
April	18	5	21	3	17	5	16
May	45	4	19	10	13	3	21
June	32	7	23	5	9	3	18
July	25	12	43	5	4	2	20

RESIGNATIONS	*April*	*May*	*June*	*July*
Dissatisfied	3	11	4	9
Another position	24	35	21	31
Left without notice			4	1
Worked too hard	4	5	7	7
Drafted	3	2	1	3
Illness	3	..	5	1
DISCHARGES				
Poor work	9	10	4	3
Intoxicated	8	12	8	18
Medically unfit	1	10	5	4

Note the number of employes who left to accept another position. The turnover in the lower bracket of kitchen help in this institution for two months was 104 and 102 per cent, respectively. This comprised a section of kitchen help, such as potwashers, dishwashers and porters.

Program for Patriots

FRED HEFFINGER

Superintendent
Manhattan Eye, Ear and Throat Hospital, New York City

LIKE all good citizens, those who are responsible for the management of hospitals are much concerned about the questions of when, what and how our hospitals can be most helpful to our country in this grave national emergency. Local, state and national associations have not only responded with alacrity to all suggestions and invitations from governmental and military authorities but have also initiated many contributory activities in defense preparation.

Wherever community organizations are set up for civilian or military defense, hospitals will adapt themselves to local conditions and will assume with earnest enthusiasm whatever share of the task is theirs: disaster units, blood banks, expansion of facilities, test blackouts. This cooperative participation has already been demonstrated throughout the country. However, the fact remains that in many cases and places the urge exists that something be done now in the way of preparation for as yet unclarified needs, that personnel be prepared and reserves of supplies and equipment be stored to meet as yet unknown demands that may descend without warning.

Here's Five Point Program

Is there a basic program that any and every hospital can adopt now, with confidence in its timely importance and usefulness, with assurance that it is free from extravagance? There is a simple program that can be expressed in four or five short paragraphs. It is not complete; it answers no questions concerning local or special needs or projects nor will it interfere with them. It is based on the assumption that each hospital will accept as its patriotic duty the internal mobilization of its own resources.

Let each hospital adopt and carry out the following pledges:

1. We will give full support to the defense program of the United States by cheerfully releasing employes and attachés who are called for military or civilian defense duties and giving such employes leave of absence with guarantee of reinstatement. We will rigidly restrict our requests for exemption or deferment to those who, because of special knowledge or skill, are virtually irreplaceable and whose loss would cripple the service of the hospital and thereby be deleterious to the general welfare.

2. We will contribute to the defense program of the United States by conducting, individually or in cooperation with other hospitals, refresher courses to refit for active service professional and technical workers who may be able and willing to resume regular duty, and by training and using volunteers. We will train our own employes for advancement and will counteract the effects of quicker turnover by efficient instruction and supervision of new employes.

3. We will contribute to the defense program of the United States by conserving the health and efficiency of our own employes through active health supervision, including periodic health examinations and allowance for adequate rest and recreation.

4. We will contribute to the defense program of the United States by strict economy in the use of materials, supplies and equipment, bearing in mind the priority needs of defense industries.

5. We will contribute to the defense program of the United States by organizing and vigorously conducting campaigns to conserve uninterrupted efficiency by the elimination of loss of working hours through preventable accidents.

This last paragraph points the way to what, at this time, rightly may be called a patriotic duty: the immediate and continuous salvage of urgently needed man power.

Statistics of insurance carriers reveal a rapid growth in the number and severity of accidents among hospital employes, particularly among professional workers. Hotels and industries long ago attacked similar adverse experience with vigorous accident prevention campaigns and collected big dividends in work hours and insurance costs saved. Hospitals can do likewise, as some have already done with conspicuous success.

Real success in accident prevention is no sinecure. It cannot be achieved by giving an order to a subordinate. It demands the constant and watchful supervision of the administrator, the enthusiastic cooperation of all department heads and, through them, the interest of every employe in the hospital.

To Prevent Accidents

Real success in accident prevention requires: (1) experience and foresight, to recognize potential hazards; (2) frequent intelligent inspection of the entire plant, with particular attention to unusual hazards, and (3) honest and thorough investigation of every accident, no matter how trivial, followed by immediate removal of the cause or education in avoiding the danger, if removal is impossible.

A salutary and helpful attitude is a general acceptance that an avoidable accident is a mark of clumsiness and stupidity and is a disgrace to the person responsible; however, care must be taken that the blame is justly placed and acknowledged. Thus, the conservation of man power becomes an achievement for which the credit, as well as the responsibility, is shared by every employe of the hospital.

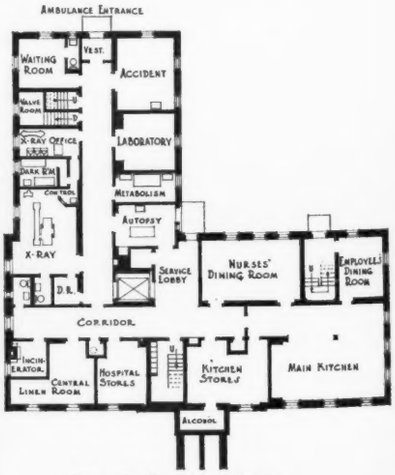
Never before has this need to conserve working time and skill been as vital as now, when doctors, nurses, technicians and skilled and unskilled workers are being called away in great numbers from hospitals into military and defense activities.

No one can foresee which hospitals may be called upon to render a spectacular or conspicuous service. The call has already been sounded for all hospitals to join in the national mobilization of resources in men and materials. Response to this call can be put under way immediately in any hospital large or small without extra investment of cash or personnel. The program asks little more than the best of good management; this is a time when good management is a patriotic duty.

Designed

Left, reading down: Tobey Hospital, exterior view showing main entrance; one section of the spacious kitchen located on the ground floor; lobby and information desk. Right, above: Corridor showing location of nurses' station and sterilizing lights. Right, below: Cheerful, commodious four bed ward. Plans reproduced below illustrate arrangement of all four floors of the Tobey Hospital.

• PLAN OF FIRST FLOOR •



• PLAN OF BASEMENT FLOOR •

For Higher Summer Occupancy

AMY J. DANIELS
Former Superintendent, Tobey Hospital, Wareham, Mass.

KENDALL, TAYLOR & CO.
Architects, Boston

CONSTRUCTION DETAILS

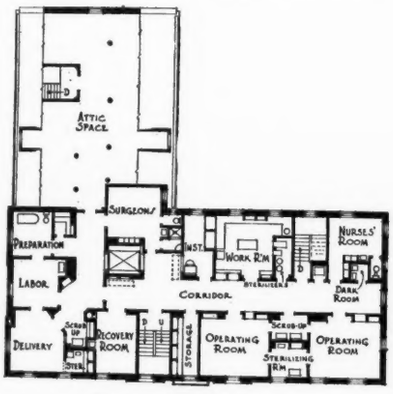
GENERAL DATA: General hospital of 34 beds and 14 bassinets, serving a rural community having a population of about 6000, with a large increase in summer months. Wareham, Mass., is at head of Buzzards Bay.

CONSTRUCTION: Fireproof construction, brick walls with limestone trim. Floors, concrete pan joist construction. Roof, gypsum slabs on steel frame with slate roofing. Windows, wood, double hung type, double glazed in air-conditioned areas. Doors, hollow metal in steel frames. Partitions, steel stud with wire lath plastered surfaces. Ceilings, plastered or of sound-deadening tile hung to construction slab to conceal piping and to allow access to conduits and piping by easy removal of tile surfaces.

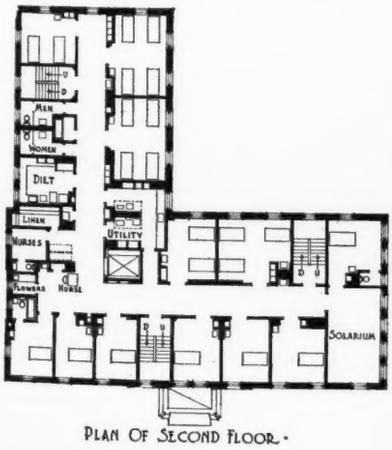
FLOORING: Tile, terrazzo and rubber tile. Rubber wainscot in operating rooms and delivery rooms and in wards behind lavatories and in all corridors.

HEATING: Low pressure steam heating from separate boiler house. Dual boilers, one with oil burner and other coal burning. Underground steam conduits to hospital and nurses' home.

ELEVATOR: Automatic push button self-leveling with power operated doors at both ends of cab. Speed, 150 feet per minute. Car has rubber floor and rubber dado.



PLAN OF THIRD FLOOR



PLAN OF SECOND FLOOR

KITCHEN: Gas cooking equipment; electric refrigeration with individual units, chilled water system; electric heated food cart service to floor diet kitchens. Incinerator in basement. Kitchen walls, ceramic glazed partition block; floors, terrazzo.

LIGHTING: Electric lighting with stand-by gasoline generator for emergency service located in boiler house. Air sterilizing equipment in operating rooms and in corridor at infants' nursery. Nurses' call system, radio outlets, telephones in all private rooms.

CLINICAL SERVICES: Complete x-ray service; morgue and necropsy room; laboratory and ambulance receiving room; basal metabolism and light treatment.

VENTILATION: Air conditioning system, located in attic, supplies conditioned air to operating rooms, delivery suite and nursery. Exhaust fans in attic for ventilating all toilets, kitchen hood, work rooms and necropsy room.

STERILIZING: Electrical sterilizers; enclosed type in operating suite, exposed type in work rooms and laboratory.

COSTS: Building, including boiler house, sewage disposal, chimney, driveways, grading and all fixed equipment, $210,000. Some of the itemized costs:

General contracts	$164,056
Boiler stack	1,258
Elevator	7,750
Metal casework	8,800
Sterilizers	6,970
Refrigeration	2,545
Rubber floors	2,412
Kitchen equipment	2,444
Lighting fixtures	1,000
Hardware	2,500
Screens	1,016

Cubage: Hospital building exclusive of boiler house, 297,400 feet.
Cost per cubic foot: 69 cents.

An Administrator Ruminates—

JOHN HAYES

Superintendent, Lenox Hill Hospital, New York City

I CAN scarcely claim to be a veteran in hospital administration. After all, fifteen years is not a long time. But it is well to reminisce at intervals and these should be short intervals, for we are likely to let time distort our views and recollections if too many years intervene. After fifteen years in a large institution I can look back and see many changes in hospital problems and practices. To me, it still remains the most interesting work there is.

The following are random thoughts on various subjects.

* * *

Trustees are almost always good fellows. The most difficult to deal with are those who feel that because they have made a success of their own businesses they know all about hospitals. This seems strange, for the same men would not feel this way about another business. For instance, a building contractor would not be of much use in a dress establishment.

However, a hotel owner or restaurant proprietor can be helpful in some departments; a public relations man's advice is useful, and there are many other instances. But very rarely is a single man an authority on many hospital problems.

Usually, trustees will find that when a sensible superintendent and a sincere medical staff are in agreement the trustee can safely approve their suggestions.

* * *

The best way to get money is to get friends. I know of one hospital that received a large building fund contribution from a man who had come to it as a patient off a park bench 20 years before. Remember the stories about kings who traveled incognito to learn how they would be received by their subjects when in other than royal raiment? They are with us today; the only difference is that ours are kings-to-be.

* * *

I think there is too much scattered research in hospitals; research is duplicated many times and much money is wasted.

Why could not all medical research be centralized in a few places, just as Mellon Institute does for industry with marvelous results? Of course, such a place would have to have a large hospital with many patients.

I should not like to be a patient in that hospital.

* * *

One of the best ways to get people to dislike your hospital is to have the accident room near the lobby and to tell the doctors to use ether or iodoform whenever possible.

* * *

Loud radios on patients' floors can give some dying patients a foretaste of what is in store for them. And it's hell for a lot of other people, too.

Fifteen years and more ago many hospitals ordered, rather than bought, their needs. Money came easy.

Today hospitals are getting to be careful buyers and do not merely order.

That is a change for the better.

* * *

After a while we shall be collecting all our charges from insurance organizations—workmen's compensation and group hospitalization plans.

* * *

Some folks say that the new taxes will kill hospital contributions entirely.

It may work the other way. So much will go to the government that the 15 per cent allowed for contributions will actually mean only 1 or 2 per cent to the contributor.

Then there is the satisfaction of giving and of withholding from the tax collector.

* * *

I like conventions, but I wonder why we do not some time have one that brings out a startling discovery of a new method of administration just as the doctors do in treatments, or the engineers and scientists.

* * *

Ladies' auxiliaries are generally like ladies: they're swell if you let them have their own way.

* * *

Hospitals use dozens of kinds of cleansing agents; new ones are concocted every day. But none has entirely succeeded in eliminating elbow grease as an ingredient.

* * *

In my opinion most nurses like to work eight out of twelve hours, rather than a straight shift. I often feel that if I had a chance to sleep a while after lunch or go to a movie I would prefer to work later and that I would work better and think more clearly.

Some superintendents do this; and they say it's great. Of course, they live in the hospital.

I wonder whether they work much after 5 o'clock.

* * *

Most patients and visitors like to hear about other patients and visitors. It is good to have appropriate stories ready for them. They become so interested they forget what they wanted to complain about or realize that theirs is not a real complaint after all.

* * *

Hospital work is different from almost all other employment. We must work under tension and never forget to be courteous and kind; and we handle not normal people, but the other kind.

After Fifteen Years

People do not excuse our lapses readily. Yet consider the traffic officer who, after seven hours of pleasant riding in the open air, loses his temper on the first timid offender or the many government employes who growl even while accepting your tax payments.

* * *

When hospital administrators meet, why do they always talk shop? I think the answer is that each one thinks his place is better than all the others and, therefore, that his story is important.

* * *

Hospitals have the worst elevator service there is and no one seems to mind it—except doctors and patients and visitors and salesmen and employes.

* * *

Sometimes I wonder whether we do not use our equipment unnecessarily and to the detriment of education. Most x-ray and laboratory work today is used to determine a diagnosis rather than to prove one already made.

The ease with which these facilities can be ordered has resulted in the fact that today our ward patients cost us more for special services than do our private patients. Doctors are loath to order and to have private patients pay costs or higher rates for these services. They rely to a greater extent on their medical knowledge and experience. On the wards routine orders are written promiscuously. Even to a layman this would seem detrimental to intern and resident education.

* * *

This brings to mind another thought. Each month in our hospital we publish for our employes a bulletin entitled "Bouquets," giving excerpts from letters received expressing thanks and commendation from patients. We have four times as many ward beds as private rooms, yet the majority of such letters are from private patients, who generally have had less special service, not nearly as constant nursing and, perhaps, the service of only one doctor, compared with the large ward staffs and consultants. And the private patients pay for everything.

Which proves the truth of the saying that we appreciate most that which costs us most.

* * *

Quite generally, student nurses are no longer exploited. This is a vast improvement over previous practice, even fifteen years ago. We turn out at least as good nurses but I think we have to produce more nurses to meet a comparative demand. It may be that more time for leisure and personal care has resulted in more early marriages and thus greater loss of young trained nurses.

This might be tried in any hospital: compare the percentage of those still active in nursing who were graduated in 1925 with the class of 1935.

It seems to me that the appearance of disrepair or disorder in some hospitals is due entirely to "patch work." That is, the hospital mechanics do repair jobs and lack the materials or workmen to restore the area to its original appearance. A good rule for any hospital is: "All repairs must result in restoration to appearance when new." It is surprising how much this will do to tone up the place; it costs little more, sometimes even less.

* * *

Inefficient painters are like inefficient doctors—their treatments result in no improvement. And it sometimes takes a long time to undo their work.

* * *

Group plans for hospitalization have proved their worth. As this is extended to ward care and as doctors are also paid, the general character of hospitals will change. This will bring up many problems. I fear that it will not improve the care of the patients. Doctors should be paid for their services, but they were never intended as users of time clocks or as piece workers.

* * *

And after another fifteen years of perhaps greater changes I may change my views.

* * *

We have seen a marvelous growth in social service in fifteen years. This is as it should be, but I wonder whether we are as careful in choosing and supervising these workers as we are about nurses.

An error by a social worker can undo much that medicine has accomplished, just as good social work can add immeasurably to medical care.

* * *

Community drives are useful, but I think they take away some personal interest in an individual institution that might have brought in greater donations.

I should not like to see my hospital lose any of its loyal supporters because they felt that one general contribution discharged their debt to the community.

We are usually more ready to help our relatives than our neighbors.

* * *

Hospital magazines are like garden magazines. Each season someone writes—in different words—the same thing as appeared the previous year.

But garden magazines have more poetry in them.

* * *

Municipalities or counties do not really give hospitals tax exemption. Each taxpayer merely pays a little more than he would if others occupied the hospital's property.

* * *

Too many people are now thinking up legislation for hospitals and doctors.

(*Continued on page* 137)

Luther Cares for Its Infants

NELS E. HANSHUS

Administrator
Luther Hospital, Eau Claire, Wis.

CARL A. ERIKSON

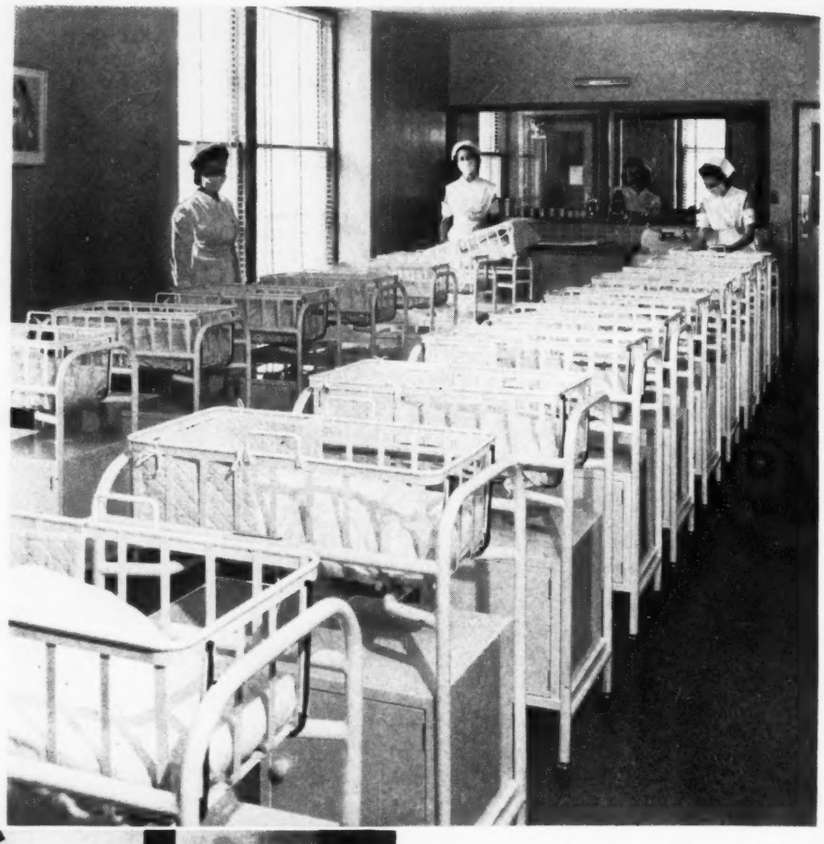
Schmidt, Garden & Erikson
Architects, Chicago

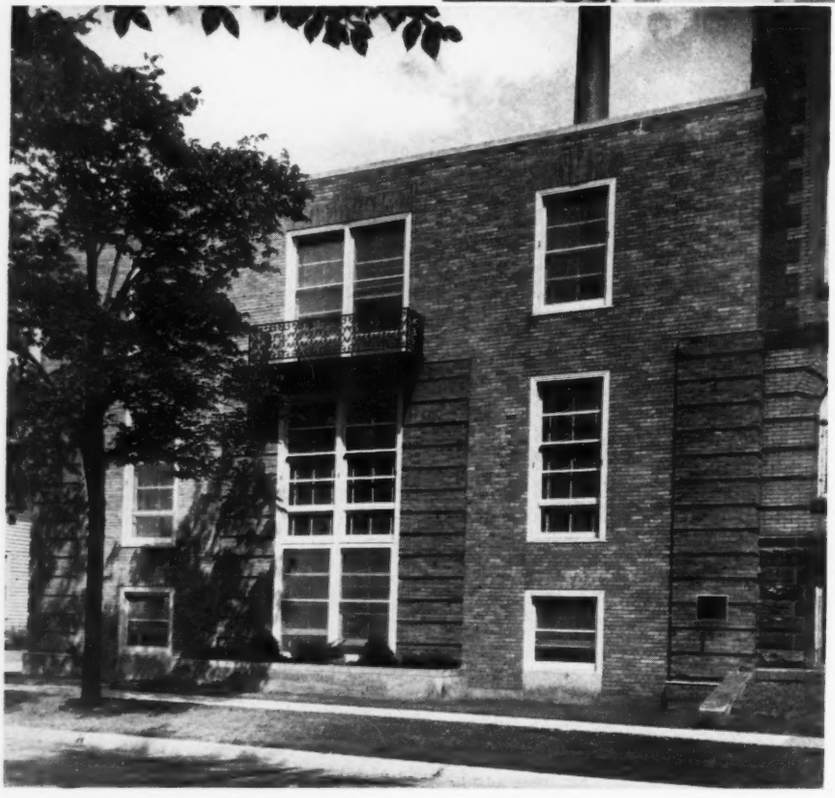
PERHAPS, because the maternity is no longer the Orphan Annie of hospitals, births in them have nearly doubled during the past decade with attendant strain on the physical resources of many an obstetrical department. Simultaneously, careful technics in the care of mother and baby, their segregation from all other kinds of patients and restrictions as to visitors have added to administrative problems caused by the increased census.

Meeting this two-pronged problem, more obstetrics under better conditions was the basic objective of Eau Claire's 155 bed Luther Hospital.

As there was no room within its existing walls, a small addition was necessary. Its second floor houses medical patients and its ground floor houses interns, an ambulance entrance, central stores and a new diet kitchen. Of special interest, however, is the first floor, the maternity division.

The existing hospital wing to which this unit is attached accommodates 30 mothers in an area that is completely segregated from all others and is cut off from visitors and hospital traffic. Only a few minor alterations were necessary to make this suitable for maternity cases.

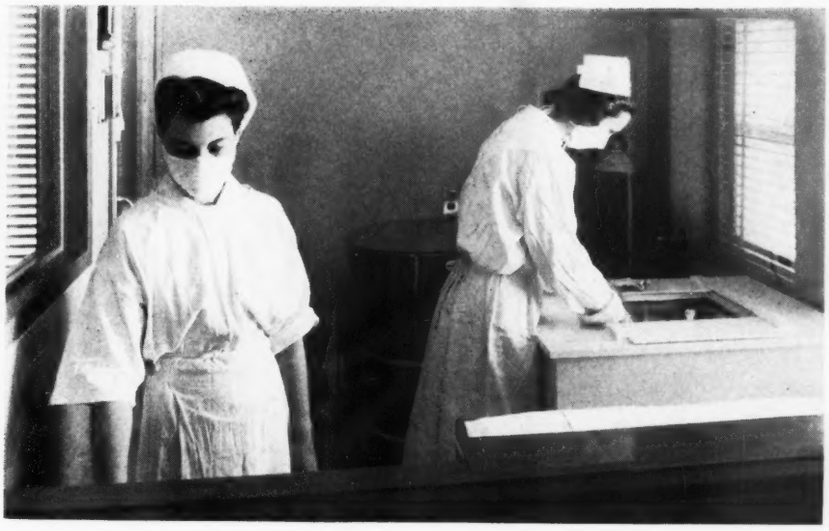




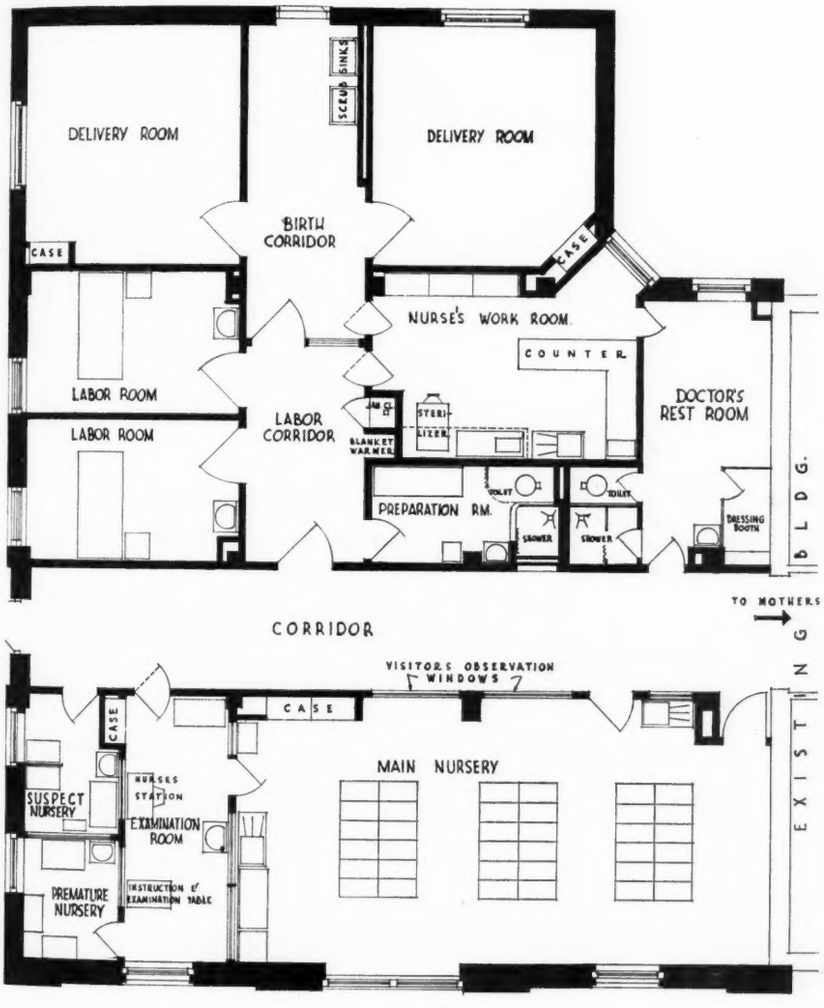
Above: Main nursery with individually equipped bassinets. Left: Exterior view of Luther Hospital's new nursery wing showing how it connects with the main hospital building.

Should enlargement of the present birth department ever be necessary, an eastward expansion could be made. That would presumably accompany an increase in the beds for mothers, readily accomplished in an addition to the north of the nursery. The main nursery now has the liberal allotment of 33 square feet for each of its 24 bassinets, thus permitting a bassinet increase of about 50 per cent without violating present day standards.

Birth room corridor. The door in right foreground leads to nurses' work room. The door back of nurse leads to one of the delivery rooms.



Premature station as seen from the suspect nursery. This room, as well as the delivery and labor rooms in the new birth and nursery department of Luther Hospital, is completely air conditioned, except for cooling. Temperature and humidity are controlled automatically at all times.



BIRTH DEPARTMENT & NURSERY
LUTHER HOSPITAL
EAU CLAIRE WISCONSIN

SCHMIDT, GARDEN & ERIKSON - ARCHITECTS
104 SO. MICHIGAN AVE. CHICAGO

N.

GRAPHIC SCALE

Construction Details

CONSTRUCTION: Foundation, concrete. Exterior walls and bearing walls, brick. Exterior walls, insulated. Floors, reenforced concrete. Partitions, hollow tile. Doors, wood with flush steel frames; window frames, wood except on fire escapes.

FLOORING: Floors and base, terrazzo with linoleum tile runner in corridor. Grounded brass grid, explosion-proof outlets in delivery room.

WALLS: Tile wainscoting behind sterilizers and back of sinks in nursery.

CEILINGS: Acoustically treated in corridor, birth rooms, labor rooms, nurseries and examination rooms.

VENTILATION: Exhaust ventilation from toilets, nurses' work room and preparation room. Winter air-conditioned nurseries, with automatic control of temperature and humidity both summer and winter. Cooling unit not thought to be necessary but provision made for future installation should it be found necessary later. No recirculation of air from premature and isolation nurseries. Windows in air-conditioned units double glazed.

HEATING: Steam; convector type of radiators.

PIPING: Hot water, copper; cold water, galvanized steel.

LIGHTING: Night lights in corridors and rooms.

CALL SYSTEMS: Nurses' call and emergency nurses' call from patients' rooms, labor rooms and delivery rooms.

Outline for Apprentice Survey

ANTHONY J. J. ROURKE, M.D.
Physician Superintendent
Stanford University Hospitals, San Francisco

EVERY medical student, early in his training, commits to memory some outline similar to the following for use in his approach to the medical problem: chief complaint; present illness; past history; physical examination; diagnosis or impression; program of treatment or study; follow-up; progress notes.

At first the young doctor thinks of this outline as much as he does of the patient, but as time goes on the outline, which has aided in the formation of a habit of thoroughness, loses form and he automatically covers the ground without overlooking anything.

A somewhat similar outline might be used by the apprentice in hospital administration in his survey work to develop thoroughness and perspective.

Such a guide will help give the apprentice a reason for his survey. All too frequently the student is placed in a department and told to survey it without further help. The superintendent is too busy to acquaint him with the methods of approach. The department head, who sometimes is not in sympathy with the survey or with the instruction of embryo administrators, does little to aid the student to get started. Consequently, he spends many confused days trying to get his teeth into something material and becomes discouraged before he gets started.

The following suggested method of approach may be rearranged to suit the student. All or parts of it may be applied to any department in the hospital. As in the case of the medical student, after the method and aim of a survey are assimilated the outline may be discarded. For purposes of illustration, the outline as it applies to a laundry of a hospital will be discussed.

A survey by the apprentice should be a physical examination, a fact finding project, while at the same time it constitutes a laboratory method of acquiring knowledge. No impressions or diagnosis should be made until the physical examination is complete.

Purpose.—If the superintendent assigns the student to a department he should clearly outline the "chief complaint." In the case of a laundry it might be: old equipment and contemplated purchase of new equipment; high cost of operation; production of a poor piece of workmanship, or a dispute between the laundry foreman and some other department.

The embryo administrator requires help and wise direction during the early stages of his apprenticeship, especially when surveying hospital departments. This outline has been designed to see the beginner safely through his initial endeavors

Personnel.—In surveying the personnel it is well to draw up a chart so that the entire picture can be seen on one sheet. A few brief remarks on each column in this chart will serve to illustrate the purpose of collecting such information.

1. Name. Here is an opportunity for the apprentice to practice memorizing names. By spending a few weeks in any department of 30 people he should be able with a little effort to recognize them by name.

2. Position. Every position should be identified by name, such as "watchman," "foreman," "distributor." In addition, an adequate description of the position should be made in the nature of a condensed job analysis.

3. Sex. Certain tasks are performed better by men than by women, while in others the reverse is true. The apprentice should not accept what he finds as being correct but should try to determine in his own mind which is the better.

4. Age. In certain cases employes who have spent many years with a hospital remain on the same job simply because they have always held it even though their efficiency has lowered with their advancing years. Could they be assigned to a new task at better advantage? The apprentice should try to set a minimum and maximum age for each task, realizing, of course, that exceptions may be warranted. Physical build should be coupled with age studies.

5. Education. An excellent washman may never be eligible for promotion to a foreman because of his inability to read or write. Perhaps a girl working on the shake-out table would be happier and would work to better advantage as a distributor and marker because of her high school education.

6. Duration of Employment. A man with five years' service who has ability will, of course, be a better worker for promotion than one with less than a year, even though slightly more qualified. In personal discussions with employes their opinions should be evaluated in light of their experience.

7. Previous Experience. If the student does not know that the washman was in charge of the laundry at X hospital for ten years he may overlook a source of information that may prove very helpful.

8. Temperament. If the department calls for close cooperation of the workers, as in a laundry, it is imperative to team up congenial people. It would be poor judgment to pair up a slow, plodding, steady worker with a high-strung, temperamental type. All of one kind or all of another may work well, but certain types should never be mixed.

9. Adaptability to Work. Is the woman operating the presses well adapted to her work or is she merely filling in until she can obtain a position in a beauty parlor?

10. Teamwork. Is the extractor man a rugged individualist when he should be a teamworker to cooperate

with the washman and the tumbler-man?

11. Promotion. Is the assistant foreman capable of moving into the foreman's job when the occasion arises? Is the assistant washman capable of taking over the wash-room?

12. Salary, Sick Leave, Vacations Within the Department. Do inequalities in salaries exist which lead to discontent? What incentive exists for better work? Does the hospital pay the prevailing rate for laundry workers in the community?

Considering the entire personnel of the department, does it function well or is there discord among the workers? If there is, does it appear to be caused by poor supervision, poor equipment, poor assignment of duties or inadequate staffing? Taken individually, each worker may be capable, but it is more important that, taken as a group, the personnel functions well.

Physical Structure.—It is important not only to know who is in the department under survey but also to know where it is located and how it is housed. It is well for the apprentice to develop an inquiring mind. He should not accept the location of the department as the best one but should try to decide where else it could be located to advantage. However, he must be sure to know all the reasons why it should not be relocated.

The parts of the physical structure should be surveyed separately:

1. Flooring. Is it concrete, wood, rubber, tile or linoleum? Why was that particular flooring selected? Does the apprentice think it was a mistaken selection? Does the flooring lend itself to cleanliness and is it being maintained properly?

2. Walls. Of what material are the walls constructed? What type of paint has been used, flat or enamel, and why? What color was used and how does it fit into the particular function of the department under survey?

3. Ceiling. What methods have been used for light reflection and sound absorption? What would the student recommend and what would it cost?

4. Size. The size of any department bears a direct relation to the number of beds in the hospital plus the addition of any out-patient department needs. The student should determine by observation over several days, including at least one peak period, whether the department has too much or too little space. Some studies in cubic footage in the department per bed in the hospital will stress the direct relationship. At a later date this figure should be compared with the same department in other hospitals.

5. Ventilation. Is the department dependent upon outside windows or mechanical devices for ventilation? In the laundry what steps have been taken to furnish the required ventilation?

6. Heat. What type of radiation is in use? Is it too hot or too cold?

7. Light. Is the lighting modern? If not, what steps can be taken to improve it?

8. Rest Rooms. Are they near and are they adequate?

Equipment.—If an inventory is not available one should be taken showing date of purchase and cost at time of installation. A trip to the accounting office should be made to determine the depreciation and replacement policies.

Perhaps the most important part of the survey of any equipment is to determine what its efficiency is. In the laundry the extractors should be checked to see that their revolutions per minute are as high as indicated for the equipment. The mangle should be checked for proper steam pressure and temperature. The air pressure to the presses should be determined.

It would be impossible to list all the equipment in a hospital to be checked and the methods of checking it. It is sufficient for the student to know that all mechanical and electrical equipment can be checked for its efficiency and that from time to time failure to make necessary adjustments and repairs may sacrifice a large percentage of the efficiency of the equipment.

In surveying a department with several pieces of equipment the student should consider the location of pieces of equipment in relation to one another. During the entire survey the apprentice should constantly be on the alert for lost motion. Even the location of the telephone within a department may cause wasted effort. Should there be a telephone? If so, should there be more than one?

Function.—Now that the student is oriented in the department, he should ask himself: What is the reason for its existence? Why should the hospital operate its own laundry? Before his survey is complete he should be able to answer all such questions in a few concise sentences.

When he determines what the function is he should then determine the load carried by the department; if it is the laundry, the pounds per patient day; if it is the painting department, the area covered per month; if it is the eligibility office in an out-patient clinic, the number of interviews per month.

Once the load being carried is ascertained he should determine if that load is at its minimum. In the case of the laundry is the nursing staff using 20 pounds per patient day instead of 13? The mere existence of a great load in any department is not in itself justifiable evidence of the needed expenditure. No survey is complete until the surveyor attempts to determine what the minimum load should be and how near to it the actual experience has proved to be.

Under the heading "Function" the student should consider the cost of operation. He has previously determined the expenditure for salaries and now he should determine the other expenses. Whenever possible, this cost should be translated into a unit cost, viz. per meal cost, per pound laundry cost, per patient day cost, per operation cost. Such unit costs should be compared with other hospitals at a later date.

Traffic studies should be carried out in an attempt to determine any resistance to the flow of the product, whether it is a sheet through the laundry, a patient through the out-patient department or a potato through the dietetic department.

Finally, the student should pass judgment on the product. Is the linen white, are the meals palatable, is the paint job good?

Relationship to Other Departments.—A great many departments of the hospital are closely related, some more closely than others. The laundry is more directly concerned with the department of nursing and the housekeeping department than with the engineering department. The apprentice should make two lists of hospital departments coming

in contact with the one being surveyed. One should be headed "Major Contacts" and the other "Minor Contacts."

In the case of the laundry the nursing staff can lend helpful cooperation or act as a detriment to the operation of the laundry. Is the delivery of soiled linen to the laundry carried out in the proper manner? In turn, does the laundry supply the nursing department with extra linen to carry over a Sunday and a holiday when they occur together? Does a cooperative spirit exist between the laundry and all the departments coming in contact with it; if not, why not? Does the nursing department realize what it means to have a washing machine break down for four hours on a busy Monday morning? Does the laundry foreman realize what it means to have four very ill patients needing frequent changes of linen with an empty linen closet?

Comparison With Other Hospitals.—After the student has learned all he can from his own department he should visit as many other hospitals in the neighborhood as possible. He should compare salaries, physical plant, equipment, production, unit costs and unit production.

In making such comparisons, of course, the student should be careful to evaluate all the important differences so that the comparisons may not be unfair or biased.

Summary of Survey.—When the surveyor has completed the foregoing study he should leave the department and write up a detailed summary to be part of his own working papers. This will be one of the most important parts of the survey to the apprentice and he should spend considerable time upon it.

Some superintendents will want to go over the working papers in detail and discuss them with the student as he goes along. Others will want only a condensed report describing the troubles and suggesting remedies.

In other instances it will be good experience for the student to summarize in concise form the results of his study. A diagnosis should be clearly stated with only enough facts to support the diagnosis. A prognosis should be made by the student, giving his opinion of the future of the department and recommending steps that should be taken in the future.

WOMEN'S SERVICE GROUPS

A Birthday Club

• Why not start a Birthday Club, as they have done so successfully at the Moore County Hospital, Pinehurst, N. C.? It was organized some six or seven years ago by an English woman living in that section who, as a child, had been accustomed with her brothers and sisters to give a cash donation on their birthdays to a certain orphanage. She decided that the same idea might be developed among the children and the parents of Pinehurst.

Mrs. Paul Dana tells us that today this comprises a large group that is increasing steadily. Not merely the children but adults, too, are most enthusiastic.

"Members are solicited," Mrs. Dana explains. "When one becomes a member, the chairman of that branch places the name on her file. Then, on the member's birthday, a form greeting card is sent. In acknowledgment, the member is supposed to send in to the chairman whatever he or she is financially able—a nickel, a dime, a quarter, a substantial check or a glass of preserves. Only the day of the month is tabulated, not the year of birth, in order to eliminate reluctance to join because of any mistaken idea that ages are checked."

Mrs. Dana has another interesting project to tell about, namely, chain parties. These are essentially a problem in arithmetic.

The chairman starts by giving a party of any kind for 16 people. Each one of these 16 gives a party for 12 people; then each of the 12 asks eight, and each of the eight asks four. The hostesses ask their guests to contribute $1 each or she may ask twice as many people and charge 50 cents. This enables people of all circumstances to take part. Here is the way it works out:

Original 16 people	$ 16
Each 16 asks 12 people	192
Each 12 asks 8 people	1536
Each 8 asks 4 people	6144
Total	$7888

Of course, in a small community, as Mrs. Dana points out, the same people double up and are asked and obligated repeatedly. "It is important, therefore, to invite only those who are truly conscientious about fulfilling their obligation of carrying on."

Card parties are always popular, as are garden parties, musicales and recitals. Putting and golf events have done well and so have sightseeing tours for hotel guests. It is truly a test, as Mrs. Dana puts it, "to outwit thy neighbor." There is but one stipulation. All parties must be simple and inexpensive, the argument being "that it is better to give the extra cost of expensive parties directly to the hospital than to spend it extravagantly."

Opportunities Are Many

• Volunteer services may be roughly classified as either auxiliary or basic services, according to Beatrice Fischer Meyer, secretary of volunteers, the Society of the New York Hospital, New York City.

"Auxiliary services," Mrs. Meyer explains, "mean services which are not vital to the patient's well-being but which do assist greatly in facilitating his adjustment to the hospital environment, a tremendous assistance to the patient as well as to the doctor. The patient's library service, the diversional therapy service, the hostess service and the plant service are examples of the auxiliary type of service.

"At the Strong Memorial Hospital in Rochester, N. Y., as well as at Johns Hopkins Hospital in Baltimore, volunteers have worked out a system of lending plants to the patients similar to a library service. These volunteers also care for the plants and replace them when necessary.

"Basic services include: clerical assistants in the clinic; ward service in which the volunteer assists the nursing service by doing simple routine things under supervision, *i.e.* helping with the laundry, making beds, answering the telephone, arranging flowers, typing and routine clerical work in the offices, secretarial service and assistance in the playroom where children wait to see the doctor and where they play prior to going home. Some hospitals have play ladies to amuse the children in the wards.

"In other hospitals there are opportunities for volunteers with theoretical training to receive practical experience in the laboratories by doing supplementary service for an extended period of time. Volunteers also may assist in various kinds of routine work under the supervision of the social service department. In communities having no motor corps available, volunteers may act as escorts for those patients who are required to come to the hospital for physical therapy or heliotherapy treatments."

Volunteers also can be of great assistance by applying their specialized knowledge, such as photography or art, to the hospital departments.

Mitigating the Nurse Shortage in the Psychiatric Hospital

ISABEL M. REARDON, R.N.

Director, Nursing Service
Colorado State Hospital, Pueblo, Colo.

Benefits have accrued to the ambitious young people as students, the hospital as teacher and patients as recipients of expert care since this six months' course for psychiatric nursing aids was instituted at the Colorado State Hospital in Pueblo

A GREAT deal of thought is being given to the present lack of nurses in general hospitals and for military services and to the probability that this shortage will become acute. In most of the mental hospitals in the United States a shortage of nurses has been acute for many years.

The need for graduate nurses in mental hospitals, except in and near teaching centers, has been recognized only comparatively recently. In many cases it has not been easy to introduce the graduate nurse into the wards of these hospitals because of the marked antagonism of the untrained attendants who have become firmly entrenched in the work. It is probable that this is one of the reasons why, even when there was unemployment in the nursing field, those nurses who did come in were hard to keep.

Regardless of whether nurses can be obtained or not, the ever increasing number of mental patients has to be cared for to the best of our ability. It is dangerous to have untrained and unsuitable attendants attempt to give nursing care to acutely ill patients. In the mental hospital, physical illnesses are bound to occur and general hospital care must be given to those patients.

With the advent of insulin and metrazol, new need has been felt for nurses. Those patients who are acutely ill mentally need understanding care, although it must be remembered there are hundreds of attendants in mental hospitals who do exceptionally good work with chronic disease patients. To give the best care and treatment as we now understand them has been a difficult problem for those of us whose duty is to provide such care.

After fruitlessly seeking all over the country for nurses, we have tried to solve the problem in our hospital of 4300 patients, the only state hospital in Colorado, by giving an intensive six months' course to young high school graduates who are residents of the state. We feel that residents will have a greater interest in the patients, many of whom they have known, and will be more dependable than those whose interests are elsewhere. Moreover, this being a land of dry farms, stock ranches and mines, there is scant opportunity for young people to find employment after graduation from high school. The course fits them for satisfactory work that is permanent.

Many of these young people are ambitious and want to continue their education in nursing schools, medical schools, social service and general college work after the course is completed. Some have saved their money and have gone to other colleges, returning here to work for the summer. There is a junior college in town and, as we have an eight hour day, many enroll there while working here. Some of them are carrying full schedules.

The classes enter in October and April. Newspaper and radio publicity is given all over the state. The C.C.C. camps are contacted. Some of our best boys have been assistant leaders in camps, assistant educational advisers, company clerks and camp infirmary attendants. Applications are carefully examined and those who appear suitable are instructed to come in for interview, personality and intelligence tests. The course is difficult, and we cannot afford to take people who are bound to fail.

When all the preliminaries have been satisfactorily completed, the applicant's high school principal and other responsible people are sent a questionnaire. Upon receipt of satisfactory replies, the applicant is notified of his acceptance. An allowance of $25 a month with full maintenance is given and the student is expected to remain at least one year in the hospital service after graduation. We make exceptions for military service now. We stress the fact that this is not a course of nursing but is intended to bridge the gap between the graduate nurse and the untrained attendant. As these students are immediately absorbed into the hospital, they do not go out into the community and call themselves nurses. If, after the year is up, they leave for good reasons and with good records, they know they can always come back; usually they do.

During the course they are considered as students, not employes. Every hour of every day is scheduled for them, the day usually beginning at 8 o'clock and ending at 5:30 o'clock, with a two hour interim at noon. Classes are held five days a week, three or four hours each day; students are free either Saturday or Sunday. The day they work they spend eight hours on the wards. They are sent to selected wards, where graduate nurses or previous graduates of the course are in charge. Students are rotated every month completing the circuit of two hospital wards, one receiving ward and one chronic disease ward; they spend two weeks each in hydrotherapy, minor surgery, the laboratory and the isolation ward. Classes are given in occupational therapy and students work out their own projects.

We try to give about two hours of clinical instruction for each hour of theory. If a student fails in three or more subjects, fails to adjust himself, has poor ward reports or mis-

conducts himself, he is dropped. Monthly conferences concerning the students are held with the charge nurses of wards in which they are placed, the instructors and the director of the nursing service in attendance. Marks and reports are then gone over with the student by the director of the nursing service.

The curriculum subjects are taught by physicians and nurses well prepared in the particular field and by the director of the nursing service.

Students carry procedures cards. After having the theory and demonstration of the nursing procedure, they must perform it on a ward under supervision of a qualified person, who signs the card if the performance is satisfactory. If unsatisfactory, it must be repeated until it is acceptable. Then the student is permitted to go ahead by himself.

Two textbooks are required. Other material is duplicated and distributed. We have a regular classroom and a practical nursing demonstration room. There are reference books in the classroom. Examinations are given upon completion of each subject. Required grades range from 70 to 80. When the course is completed, the students are formally graduated and certificates are awarded. The graduates wear insignia to identify them.

These classes were started in October 1937. At first we took 12 boys and twelve girls, boys in the age range of from 19 to 25 and girls from 18 to 24. The age limit has become more elastic now. In October 1939 we increased the number of students to 24 boys and 24 girls.

These classes have not only provided us with people who have at least a basic training in their work but have also been a decided factor in pleasant public relations. The newspapers are interested. Lists of those accepted are published. The papers carry lengthy accounts of graduation and pictures of the graduates. Relatives and friends of the students attend and go through the hospital. Selected students are trained as guides to take visitors through the institution.

So far we have not nearly a sufficient number of graduate students. To cover the wards, more than 600 attendants are necessary, of whom 125 are graduates. Like most mental hospitals, our turnover is high, especially now with the military services calling male attendants.

Curriculum for Psychiatric Aids

Subject	*Hours*
Hospital rules and regulations	8
Practical nursing	80
Symptomatology	8
Personal hygiene	12
Psychiatric nursing	75
Drugs and solutions	20
Materia medica	16
Emergency, first aid and bandaging	20
Medical nursing (including some bacteriology and communicable disease)	30
Surgical nursing	16
Anatomy and physiology (including some dietetics)	60
Hydrotherapy practice (along with two weeks' class)	10
Occupational therapy	6
Clinical pathology (collection and care of specimens, blood for Wassermann tests, spinal fluid)	8
Ward management	6

Recently, we lost 30 graduates to the Naval Reserve. About eighteen months ago when the neuropsychiatric technician branch was added to the Naval Reserve, we submitted to the bureau of medicine and surgery of the Navy Department, through the commanding officer of the local Naval Reserve unit, a copy of our curriculum and an outline of our course. The bureau authorized the enrollment of our men graduates as first and second class pharmacists' mates, according to experience, upon submission of a photostatic copy of their graduation certificates and recommendation. While this recruiting helps national defense and promotes favorable publicity both for Navy recruiting and for the hospital, it is taking our best boys.

In order to fill these vacancies we are adding to the class a section composed of women between the ages of 35 and 45 to work on the men's wards. These women, the first group now in training, are selected in the same way as the younger students, except that we have not insisted upon high school graduation for those over 40; however, we do insist upon a high I.Q. score. A number of the women enrolled are widows who formerly taught school. We feel that suitable older women not only will provide us with desirable ward employes but also will ensure security for a group little in demand.

A further good result of these classes has been a general improvement of morale. There are an educational atmosphere about the hospital and an interest in learning and improving the care of the patients that were sadly lacking before.

Schedule of Duties for Nurse Aids

7-7:30 a.m.—Remove extra night blankets; clear and place bedside tables for breakfast; answer lights during morning circle.

7:30-8 a.m.—Assist in passing and collecting breakfast trays.

8-11 a.m.—Collect, wash, and refill water pitchers and glasses; change water on flowers; prepare and serve delayed breakfasts; help nurses with lifting and moving difficult patients; take patients to other departments; pass the 10 a.m. nourishments under the direction of nurse in charge; make beds of ambulatory patients; make anesthesia beds; go on errands; clean utility rooms; take inventories of rubber goods and enamelware.

11-11:30 a.m.—Help in passing and collecting lunch trays and in preparing liquid diets.

12-1:00 p.m.—Pass fresh water; deliver mail.

1-4 p.m.—See that rooms are in order and that patients are ready to receive visitors; clean and boil enamelware; help with discharging patients; clean and make up units after discharge of patients; make up linen packs and clean linen room.

4-5 p.m.—Pass wash water to patients; arrange bedside tables for supper.

5-7 p.m.—Assist with passing and collecting evening trays; assist with evening care of difficult patients; straighten beds of ambulatory patients; pass fresh water.

7-11 p.m.—Answer lights during evening, report to relief nurses; provide extra blankets; prepare evening nourishments; assist in cleaning equipment, treatment rooms and utility rooms.

11 p.m.-5 a.m.—Rule temperature books and intake and output sheets; help answer lights; make supplies.

5-6 a.m.—Assist in collecting specimens.

6-6:30 a.m.—Pass wash water.

6:30-7 a.m.—Collect extra blankets; put ward in order.—*University of Minnesota Hospitals.*

The Convention News

October 1941

Resolutions Urging High Supplies Rating Adopted by Hospital Associations

Resolutions urging that hospitals be given priorities on their needed supplies and equipment sufficiently high to enable them to continue to operate at high professional levels and at full efficiency were adopted by the American Protestant Hospital Association and the American Hospital Association. Although the resolutions were different in wording, the general intent was similar.

Such resolutions were suggested by the committee on priorities affecting civilian hospital and medical requirements at a meeting in Chicago earlier in the month. The committee prepared a fairly extensive list of classes of supplies and equipment for consideration of O.P.M. officials but these were omitted from the resolutions adopted by the hospital associations.

During the time of the meeting, the anonymous advisory committee of the Health Supplies Rating Plan of O.P.M. met in Washington and recommended to Donald M. Nelson, director of priorities, the addition of a considerable group of items to the health supplies

(*Continued on page* 136)

A.H.A. OFFICERS FOR 1942

President: Basil C. MacLean, M.D., Strong Memorial Hospital, Rochester, N. Y.

President-Elect: James A. Hamilton, New Haven Hospital, New Haven, Conn.

First Vice President: Clyde L. Sibley, Baptist Hospitals, Birmingham, Ala.

Second Vice President: Regina Kaplan, Leo N. Levi Memorial Hospital, Hot Springs, Ark.

Third Vice President: Rev. John J. Bingham, diocesan director of Catholic hospitals, New York City.

Treasurer: Asa S. Bacon, Dowagiac, Mich.

Trustees: Jessie J. Turnbull, Elizabeth Steel Magee Hospital, Pittsburgh; Stuart K. Hummel, Silver Cross Hospital, Joliet, Ill.; George U. Wood, Peralta Hospital, Oakland, Calif.

Delegates at Large: Eleanor E. Hamilton, Presbyterian Hospital, Newark, N. J.; George W. Stephens, M.D., Royal Victoria Hospital, Montreal, Que.

A.H.A. DELEGATES ARRIVE AT ATLANTIC CITY STATION

A.H.A. Votes Confidence in Officers; Pledges Cooperation in Defense Effort

A strong vote of confidence in the work of the president, the president-elect, the trustees, the councils and other officers of the American Hospital Association was the outstanding feature of the recent Atlantic City convention.

Although there had been a great deal of agitation in various quarters to upset the work that had been done by the trustees and other groups, looking toward the extending of full institutional membership to approved hospital service plans, when actual voting took place the program worked out by the officers was overwhelmingly approved.

There are 67 approved Blue Cross plans that are eligible for membership in the association as Type IV members under the new amendments to the constitution adopted by the house of delegates. These plans have approximately 7,500,000 subscribers and dependents.

When the slate of members of the new hospital service plan commission was announced, it was found that four hospital administrators and two former hospital administrators had been named to serve on the commission. This was more representation than had been asked for by those who were opposing the constitutional amendments.

The officers who had served on the interim hospital service plan commission were reelected by the new commission, thus indicating a vote of confidence in them and appreciation of the arduous work they have carried on during the last year.

The problems incident to national defense, including the shortage of personnel, the difficulties surrounding the priorities situation and the growing financial problems of hospitals, all received serious and extended attention. Full reports on these subjects appear elsewhere in this section.

Evidence of a growing rapprochement

(*Continued on page* 76)

Attendance Just Short of 4400

The registration figure for the convention was around 4400, including A.P.H.A., A.C.H.A., nurse anesthetists and exhibitors. Some of the registrations were, of course, duplicates since some delegates are members of two or three of the foregoing organizations.

Inter-American Group Forms Association; Dr. José Jácome Is Head

An Inter-American Hospital Association was launched by delegates from nine countries of South, Central and North America meeting in Atlantic City at the time of the A.H.A. sessions. A constitution was adopted, officers were elected and the association started as a functioning organization.

Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons and president of the International Hospital Association, was chosen as honorary president. Dr. José Jácome of Colombia was elected president. Dr. Frederico Gómez of Mexico was elected vice president and Felix Lamela of Puerto Rico was chosen as secretary.

The board of trustees will be composed of the officers and one representative from each of the countries in the Americas. Eight trustees were chosen at the Atlantic City meeting. They are: Dr. Francisco Valdivia, Mexico, Dr. Teófilo de Almeida, Brazil, Dr. B. N. Morgan, Santo Domingo, Dr. Luis González, Puerto Rico, Dr. Louis Hippolite, Haiti, Dr. Felipe Carranza, Argentina, Dr. Raul Peña, Paraguay, and Dr. E. M. Dunstan, U. S. A. Fourteen other trustees are to be elected, one each from Canada, Chile, Venezuela, Uruguay, Bolivia, Ecuador, Peru, Cuba, Costa Rica, El Salvador, Honduras, Guatemala, Panama and Nicaragua.

Because of the adverse exchange in many countries, dues were set extremely low in terms of United States dollars. The dues for active personal members are $2 per year and for institutional members, $5 per year. The latter amount in some countries corresponds to dues of $50 or $100 in this country.

The association is designed to stimulate closer cooperation of hospitals of the Western Hemisphere, to hold periodic hospital congresses (probably biennially), to discuss mutual problems and procedures for improving hospital administration, to aid in the formation and growth of national hospital associations in the various countries, to publish material of benefit to hospital administrators and provide other means of communication, to provide fellowships for travel and study, to make studies and surveys in the various countries and to aid hospital administrators, department heads and others to improve their knowledge.

1942 A.C.H.A. Officers

The American College of Hospital Administrators has named the following officers for the new year:

President: Lucius R. Wilson, M.D., Hospital of the Protestant Episcopal Church, Philadelphia.

President-Elect: Joseph G. Norby, Columbia Hospital, Milwaukee.

First Vice President: Jewell W. Thrasher, Frasier-Ellis Hospital, Dothan, Ala.

Second Vice President: Oliver G. Pratt, Salem Hospital, Salem, Mass.

New Regents: Claude W. Munger, St. Luke's Hospital, New York City; L. C. Austin, Menorah Hospital, Kansas City, Mo.; Dr. S. R. D. Hewitt, St. John General Hospital, St. John, N. B.; Donald M. Morrill, M.D., Detroit Receiving Hospital, Detroit; F. Oliver Bates, Roper Hospital, Charleston, S. C.

Executive Committee: Scott Whitcher, St. Luke's Hospital, New Bedford, Mass.; A. J. Hockett, M.D., Touro Infirmary, New Orleans.

A.C.H.A. Confers Honors; Asa Bacon Addresses Group

There is no need for pessimism in contemplating the future support of our voluntary hospitals, Asa S. Bacon, superintendent emeritus, Presbyterian Hospital, Chicago, believes, if only we will keep them before the public in a proper light.

"Don't hesitate to ask for endowment funds," he urged in speaking before the eighth convocation of the American College of Hospital Administrators. "It is the best way to perpetuate your hospital. Hospital service throughout the country will increase despite wars and panics. Other things come and go, but hospitals come and stay."

The heartening tenor of Mr. Bacon's remarks brought new courage to the audience which responded enthusiastically when he was later accorded an honorary degree. Advancement to fellowship in the college was granted Grace B. Hinckley, superintendent, Methodist Hospital, Brooklyn, N. Y. Twenty-five candidates for membership were received and four were advanced to membership. Thirty-five administrators recited the pledge to become associate members.

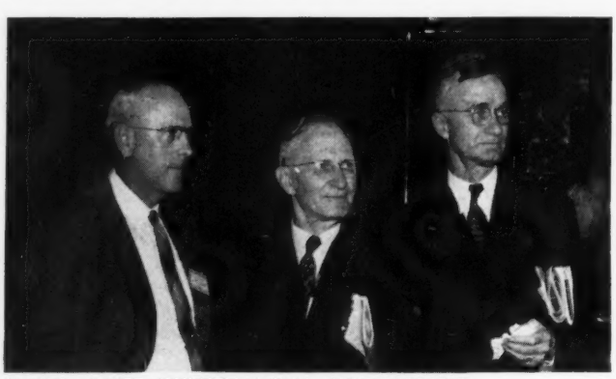
Shortage of Nurses Not Entirely Due to Defense, Miss Stewart Declares

There are 561 nurses per hundred thousand population today as compared with only 221 per hundred thousand in 1920, according to Prof. Isabel M. Stewart of Teachers College, Columbia University. Before the defense needs and other increased demands came along, the supply and the demand for nurses were pretty well balanced except for a chronic shortage of nurses on the upper levels of training and ability.

So far, only 3 per cent of the nation's nurses have left hospitals for military service, Miss Stewart pointed out, adding that this indicates that much of the shortage must be due to other causes.

She presented figures that indicate little hope of solving the nursing shortage through increasing the hours of duty of student nurses inasmuch as 61 per cent of the schools require each student to put in 48 or more hours of actual nursing practice each week, in addition to study time and class work.

A.C.H.A. PRESIDENT-ELECT AND COLLEAGUES VIEW THE CONVENTION EXHIBITS



JAMES McNEE, DULUTH, MINN., REV. HERMAN FRITSCHEL, MILWAUKEE, AND JOSEPH G. NORBY, PRESIDENT-ELECT, A.C.H.A.

ALLEN SHERMAN, SCOTT WHITCHER AND W. K. READ, ST. LUKE'S HOSPITAL, NEW BEDFORD, MASS.

Graduates of U. of C. Administration Course Organize Alumni Group

Alumni of the graduate course in hospital administration of the University of Chicago formed an organization at a breakfast meeting in Atlantic City and elected Nellie Gorgas, administrator of St. Barnabas Hospital, Minneapolis, as secretary-treasurer. Dr. Arthur C. Bachmeyer, director of the course, addressed the group briefly. He reported that 52 students had been accepted for the course since its inauguration in 1934. Of these, 22 have received a master's degree in hospital administration and others are still working toward their degree. Ten of the graduates are now administrators of hospitals and 15 are assistant or associate administrators. The rest of the graduates are personnel directors, business office or other department managers or executives of associated organizations. Dr. Arthur C. Bowles, a member of the first class, is the only graduate deceased.

The alumni group has organized to carry on contacts by means of a quarterly bulletin and an annual reunion at the time of the A.H.A. convention.

Ellis Outlines Basic Training for an Administrative Career

What does a hospital administrator need to know?

Those embarking on an administrative career should have a knowledge of such technics as personnel management and accounting and statistics, some familiarity with public health studies, social science and dietetics, and enough of engineering knowledge to discuss ordinary engineering problems likely to be met with in the operation of the institution.

Commissioner William J. Ellis of the New Jersey Department of Institutions and Agencies enumerated the foregoing requirements in his paper on "Opportunities for a Career in Public Hospital Management Through Cooperation With Civil Service and Merit System."

"In the case of public hospitals civil service systems acting as personnel agents for the institutions are in an extremely favorable position to influence the selection of employes and to be influenced, in turn, by present day practices in hospital management," Commissioner Ellis asserted.

"The public hospital will indicate the standards it wishes to maintain while the civil service administration will be the medium through which these standards are supplied and through which they are integrated with the general policies covering the operation of the merit system generally."

Bachmeyer and Hamilton Discuss Current Problems in Personnel Administration

Much care should be taken to introduce a new employe to his job, according to Dr. Arthur C. Bachmeyer of Chicago, who spoke on personnel policies with particular reference to selection, grading and dismissal in view of present conditions. The new employe should be taken on a carefully planned tour of the hospital and should be given a cordial welcome, Doctor Bachmeyer stated.

Training programs are helpful in adapting employes to their new responsibilities. Doctor Bachmeyer referred to

J. R. CLARKE AND A.H.A. PRESIDENT-ELECT JAMES A. HAMILTON

the controversial attitudes that exist regarding efficiency reports but stated that when they are made fairly and judiciously they can be valuable in proper personnel administration. He pointed out that without some such reports there is much greater possibility of injustice to the employe as well as to the hospital and that judgments regarding an employe's worth are often haphazard.

Doctor Bachmeyer urged that disciplinary measures be used with discriminating judgment. When any action beyond admonishment is necessary, he urged that the department head take it up with a higher official and that no employe should be discharged before the hospital administrator himself had reviewed the case thoroughly. When employment is terminated for any reason, Doctor Bachmeyer urged that exit interviews be held. Properly conducted, these are beneficial to both the hospital and the employe. The latter may be helped to realize some traits of his that are handicapping him, while the hospital may learn facts about its personnel policies or administration that deserve attention.

It will be necessary to raise wages of hospital employes rather substantially in the near future, in the opinion of James A. Hamilton. In order to avoid unnecessary inflation and to make it easier to change again if conditions demand it, Mr. Hamilton suggested that the increase be paid in the form of a bonus consisting of retirement insurance, disability insurance, defense savings bonds, vacation reserves or some similar benefit which will not be immediately spent by the employe. Thus the individual is helped but the nation's problem of inflation is not made more acute.

Because the supply of labor has decreased, Mr. Hamilton predicted more frequent changes in wage levels, particularly among those in the lower income groups. He expressed a hope that the wages of these groups would come abreast of the wages paid for similar work in industry and then would stay there.

There is a danger that the pressure for increased salaries for the lower paid groups may be more severe than among the more highly skilled groups. If so, the proper relationship between the salaries in these two groups may no longer be followed, Mr. Hamilton warned. He urged that hospitals increase salaries of the skilled and administrative personnel as well as of the unskilled workers.

Labor saving equipment should be studied carefully, he said, to see what economies can be effected. Full cash rather than cash plus maintenance was also favored.

When making salary changes, be sure to confer with the employes beforehand rather than only afterward, he said. He pointed out that the setting of salary scales involves many factors and that the figures on salaries published in The Modern Hospital should not be followed blindly but should be interpreted in the light of local conditions.

Remuneration for Out-Patient Work Desirable, Delegates Vote

Discussant Edgar C. Hayhow of Paterson, N. J., asked for a show of hands on the question: "How many persons in this hall pay physicians for their work in the out-patient department?"

Only five hands were raised.

"How many do not pay physicians for out-patient work?"

Some 75 or 80 persons responded affirmatively.

"How many would like to pay physicians for out-patient work?"

The same 75 or 80 hands were raised.

Present Needs Call for 10,000 More Defense Area Beds, Convention Is Told

At least 10,000 additional hospital beds are needed to meet the needs in areas where defense industries have expanded greatly and in camp areas where large nonmilitary populations have been built up, according to a survey made by the U. S. Public Health Service at the request of the subcommittee on hospitals of the health and medical committee of the Office of Defense Health and Welfare.

This important fact was revealed by Doctor Winford Smith, chairman of the subcommittee on hospitals, who believes that this estimate is much too low.

"The subcommittee on hospitals has made definite recommendations to the health and medical committee that where such needs developed in connection with military or other government projects it should be the responsibility of the federal government to make adequate provisions," Doctor Smith reported. "It was also recommended that where such needs develop in connection with the expansion of private industry for defense purposes the government should require the companies handling defense contracts to take the steps necessary to meet this situation, either through the use of existing hospitals, the temporary expansion of such hospitals or the provision of new temporary hospitals adequate for the emergency period."

Doctor Smith also recommended that the defense industries should cooperate by the use of hospital service plans. "In some instances, as in the case of nonmilitary populations around camps, there will be large numbers of the medically indigent. In all such cases the increased cost should be met by government funds."

To Protect Traveling Subscribers

To smooth the path of subscribers to hospital service plans who happen to need hospital care when they are away from home, the house of delegates voted to recommend to hospitals that they accept the membership cards of approved Blue Cross plans as a satisfactory basis for extending service to such subscribers up to the extent of the benefits that they would receive if they had gone to a hospital at home. This is now possible because a comprehensive directory of all plans and of their benefits has been published by the hospital service plan commission and distributed to all of the 1900 hospitals that are members of approved plans. The hospitals were also requested to look to their local Blue Cross plans for assistance in handling the details of transactions with out-of-town subscribers.

H. L. Goodloe Wins Annual A.H.A. Golf Tournament

Henry L. Goodloe, superintendent of Dixie Hospital, Hampton, Va., won the cup at the annual golf tournament of the A. H. A. held at the Atlantic City Country Club Wednesday, September 17. Mr. Goodloe's score was 82.

Of the 36 golfers entered in the tournament, the following, in addition to Mr. Goodloe, received prizes: C. E. Croft, H. Southmayd, C. S. Hughes, Don Hawkins, Thomas White, E. J. Lincke, R. Bew, A. A. Kitterer, William Donnelly, H. G. Haynes, J. F. Regan, D. T. Bell, E. Renehan, E. F. Franklin, R. T. Evans, D. A. Endres, Mrs. Grier and Dr. O. F. Ball.

Dr. Frederic Washburn Receives Award of Merit at President's Session

Dr. Frederic A. Washburn was given the A.H.A. annual award of merit at appropriate ceremonies at the president's session on Monday evening. Rt. Rev. Msgr. M. F. Griffin, senior trustee of the association, made the presentation.

Doctor Washburn was cited as "a public-spirited citizen of his commonwealth, as a soldier and as a hospital administrator."

Doctor Washburn served in the Spanish-American War and was a commanding officer of Base Hospital No. 6, A.E.F., in France during the World War until 1917, at which time he was given charge of the American hospitals in Great Britain. He was awarded the Distinguished Service Medal and Companion Order of St. Michael and St. George.

Until 1934 Doctor Washburn was director of Massachusetts General Hospital, Boston, following his Army service. From 1934 to 1937 he was commissioner of institutions of the city of Boston and is now consulting director of Cambridge Hospital, Cambridge, Mass.

1942 A.P.H.A. Officers

The American Protestant Hospital Association has elected the following officers for the coming year:

President: John H. Olsen, Richmond Memorial Hospital-Dreyfus Foundation, Prince Bay, Staten Island, N. Y.

President-Elect: Edgar Blake Jr., Methodist Hospital, Gary, Ind.

First Vice President: E. I. Erickson, Augustana Hospital, Chicago.

Second Vice President: Rev. John L. Ernst, Evangelical Deaconess Hospital, Detroit.

Treasurer: Ritz E. Heerman, California Hospital, Los Angeles.

Trustees (terms expiring in 1944): J. B. Franklin, John D. Archbold Memorial Hospital, Thomasville, Ga.; Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark, N. J., and Lt. Col. Ella Mae Bergner, social service department, Salvation Army, New York City.

General Reynolds Presents Army Hospital Statistics

Approximately four beds in station hospitals and one bed in general hospitals are allowed per hundred persons in the military forces, according to Major General Charles R. Reynolds, former surgeon general of the U. S. Army.

"At the present time the Army has 194 station hospitals with approximately 66,000 beds. Additional construction will bring the total station hospital beds to 75,000 in about 208 hospitals, he stated. Thirteen general hospitals are in operation, eight having been constructed during the emergency. Each has a bed capacity of 1000, except one which has 2000 and two which have 750 beds each. Their total capacity is 14,500. With a total military force of 2,500,000 men, excluding the Navy, we shall require approximately 125,000 hospital beds for military usage."

None of the reserve hospital units has as yet been placed on active duty, General Reynolds stated. "Should an expeditionary force become necessary or should strong garrisons be placed on island bases along the Atlantic seaboard, required hospital units will be drawn from the organized reserves and, more particularly, from the affiliated reserve hospitals."

Affiliated or reserve hospital units have been established in existing civilian hospitals and clinics. Of these there are 48 general hospitals, 19 evacuation hospitals and 8 surgical hospitals. "At the present time there are 1465 medical, 162 dental and 39 medical administrative reserve officers assigned to these hospitals," General Reynolds stated.

Modern Hospital Board Members Hear Preview of Convention Theme

A preview of the leading opinion on defense, which was the dominant theme of the convention, took place on Saturday evening in the Ambassador's Surf Room when Dr. Otho F. Ball with a hotel tablespoon as gavel called to order the annual meeting of The Modern Hospital's board of editors and consultants.

Chairman Joseph C. Doane, M.D., called upon A.H.A. President Benjamin W. Black for counsel to hospitals on defense development. Doctor Black sees in the spread of income taxes to low salaried workers a new financial problem for voluntary hospitals. He urges hospitals in making plans for new construction not to be carried away by defense demands but to undertake only the amount of building that will satisfy normal after-the-war effort.

Dr. Robin C. Buerki asks hospitals to speed emergency organization and to gear it to twenty-four hour a day demand in response to the program being outlined by the civilian defense commission. The fact that the medical profession and the government have tacitly acknowledged the hospital as the community center for civilian defense places upon hospital administrators a heavy responsibility.

Accelerated medical training obtained through eleven months a year courses is being done at government request, Dr. Arthur C. Bachmeyer points out, but the graduates are striking a snag in state board regulations specifying a fixed number of years of study. Governmental scholarships for medical students is a probable next step in the preparedness program of teaching hospitals, Doctor Bachmeyer believes.

How The Modern Hospital publisher as a volunteer service during the last war surveyed public buildings of the nation, even including breweries, for possible Army hospital use and how he recruited through the magazine some 2000 technicians for Uncle Sam and, later, when the war was over found them jobs in industry were eloquently told by Msgr. Maurice F. Griffin in concluding the board's informal program.

Some Baby!

An infant, immaculately diapered, lying on a table and kicking its feet in the air is not an unusual sight to hospital people, but when encountered quite unexpectedly down one of the aisles of the Atlantic City auditorium, everyone looked twice. Even then, it was hard to believe it was just a doll dressed to show advanced fall styles for the baby.

Capt. Lucius W. Johnson Receives First Modern Hospital Gold Medal Award

To Capt. Lucius W. Johnson, Medical Corps, U. S. Navy, the first gold medal and certificate symbolizing The Modern Hospital Award was presented at a dinner meeting of the editorial board held September 13 in conjunction with the A.H.A. convention.

Dr. Arthur C. Bachmeyer, chairman of the jury, presented the award to Captain Johnson *in absentia,* as the recipient could not leave his command at the U. S. Naval Hospital, Pensacola, Fla., at this time of defense development.

"We Are Already Late in Our Preparations for Aerial Bombardment" was the title of the article appearing in the December 1940 issue, which the jury of award voted the best of the magazine's output during the designated period—from July 1940 through June 1941.

No stranger to such honors is Captain Johnson, who last year wrote the Sir Henry Wellcome prize essay on "Medical and Sanitary Care of the Civil Population Necessitated by Attacks of Hostile Aircraft."

In 1936 he was named George M. Kober lecturer at Georgetown University on "Plastic Surgery and the Armed Forces."

One of the widely acclaimed articles in recent volumes of The Modern Hospital was Captain Johnson's "The Preferred Types of Construction Features," published in March 1940, a review of what 30 of the newest and best run hospitals in the country were using in the way of materials and equipment.

Doctor Johnson's prize-winning article was selected by the jury from 24 nominations for the honor. According to the rules of the competition, which is to be annual, no member of the editorial board, consultants or staff of the magazine is eligible for the award.

The 1941 jury consisted of Doctor Bachmeyer as chairman, Dr. Robin C. Buerki, Dr. Basil C. MacLean and Gladys Brandt. The contest will be repeated during the coming year and another award presented at the 1942 convention.

Chronically Ill Patients Sew for Red Cross at Montefiore

At Montefiore Hospital, New York City, a Red Cross sewing project was instigated a year ago to strengthen the chronic disease patient's feeling that he was a part of the world about him and to give the ward charity patient a chance to help someone less fortunate than himself.

The hospital equipped a room with four sewing machines for the work, Mrs. Harold M. Lehman, chairman of the occupational therapy committee of the hospital, told the convention.

During the year 120 patients, representing one eighth of the hospital's patient population, have been sewing there and they have turned out 1500 articles of clothing during a total of 5128 hours of painstaking effort.

Some of the hospital volunteers went to Red Cross headquarters to learn how the work was to be done. Other volunteers arranged for the Red Cross and other organizations to supply the patients with materials.

JOHN MANNIX, DETROIT, DR. ROBERT H. BISHOP Jr. AND GUY J. CLARK, CLEVELAND

DR. AND MRS. LEWIS JARRETT AND DAUGHTER OF RICHMOND, VA.

Hospital Service Plan Commissioners Named; van Steenwyk Is Chairman

Four hospital administrators, three plan managers and two plan trustees were named to the first permanent Hospital Service Plan Commission of the American Hospital Association in an election at Atlantic City Monday, September 15, a few hours after the commission was established and the plans themselves accepted into the association by action of the House of Delegates and Assembly.

Hospital administrators on the commission are Dr. Benjamin W. Black, director of the Alameda County Institutions, Oakland, Calif., F. Stanley Howe, superintendent of Orange Memorial Hospital, Orange, N. J., Dr. Herman Smith, director of Michael Reese Hospital, Chicago, and Dr. Peter D. Ward, superintendent, Charles T. Miller Hospital, Minneapolis. E. A. van Steenwyk of Philadelphia, John Mannix of Michigan and Dr. S. S. Goldwater of New York are the plan managers on the new commission; George Putnam, Boston, and John A. Connor, Columbus, Ohio, both plan trustees, are the remaining members. Mr. Putnam, Mr. Connor, Mr. Mannix, Doctor Ward and Mr. van Steenwyk were members of the "interim commission" elected by the plans last winter to serve until action by the House of Delegates made the permanent organization possible.

Terms of the new commissioners will be determined by lot, three members to serve terms of one, two and three years, and three to be elected each year hereafter. The plans also named delegates to the American Hospital Association as follows: three year delegate, J. D. Colman, Baltimore, and Ed Moore, Birmingham, Ala., alternate; two year delegate, Carl M. Metzger, Buffalo, and A. S. Leach, Winnipeg, Man., alternate; one year delegate, M. Haskins Coleman, Richmond, Va., and Robert J. Marsh, Huntington, W. Va., alternate.

The meeting failed to develop any opposition to candidates named as commissioners and delegates by the nominating committee, and no nominations from the floor were forthcoming. When a motion that the nominations be closed passed unanimously, the plans canceled an election meeting scheduled for Tuesday morning. Thirty-eight plans were represented in the voting.

Mr. van Steenwyk was chosen chairman of the commission, Mr. Mannix was elected vice chairman and Mr. Putnam was elected treasurer. All three of the officers, as it happened, drew two year terms. The three year terms went to Doctor Smith, Mr. Connor and Mr. Howe, and the one year terms were allotted to Doctors Goldwater, Black and Ward.

Conserve Supplies and Raise Salaries

The time is not far distant when hospitals will have to pay the personnel what their services are worth. This money will have to come out of conservation of supplies. When the personnel understands this and benefits by it, supplies will be conserved, in the opinion of Albert H. Scheidt.

Blue Cross Plans Approve 1942 Commission Program

In their final meeting at Atlantic City Wednesday afternoon, September 17, representatives of the Blue Cross hospital service plans approved a program of 1942 objectives and activities for the hospital service plan commission. A separate action by the plans approved the supporting budget in the total amount of $51,996.

Specifically, the plans voted to accept earlier action by the commission itself affecting the 1942 program and budget, formally accepting an additional grant of $25,000 from the Rosenwald Fund for use by the commission in 1942 and 1943, reelecting C. Rufus Rorem as director of the commission and agreeing to participate with the American Hospital Association in a joint program of public education for hospitals and hospitalization plans.

The 1942 activities to be undertaken by the commission include continuation of the approval program for Blue Cross plans, expanded services in collecting and furnishing actuarial and financial data in connection with plan operation, continuation of the consultation and information service undertaken by the commission office during the past year, with particular emphasis on the encouragement of efforts to establish Blue Cross plans in areas not now served, and the continued expansion of national public education as initiated in the last six months by the "interim" commission.

A study made last spring of 51 voluntary hospitals in New York showed that there were 789 men on hospital boards and only 48 women.

A.C.H.A. Approves Code of Ethics; By-Laws Revised

Approval of that section of the new code of ethics that applies to the hospital administrator as an individual was voted unanimously by the members of the A.C.H.A. at the recent meeting. The other two sections of the code, applying to the hospital in its community aspects and to the internal administration of the hospital, were presented to the A.H.A. for approval. The code of ethics was prepared by a joint committee of the two organizations headed by Dr. G. Harvey Agnew of Toronto.

The constitution and by-laws of the A.C.H.A. were also revised to remove the mandatory requirements regarding the size and character of the hospital in which an applicant must work in order to be eligible for membership. These requirements are now to be put in rules and regulations rather than in the constitution and by-laws. The associate members are now to be called "nominees" and to be considered as merely in process of becoming members and, later, fellows.

Control of Standardization Urged

Closer control over standardizing and approval programs affecting hospitals was urged in a resolution adopted by the house of delegates. The resolution urged that all agencies engaged in such work should work closely with the American Hospital Association and should consult the A.H.A. regarding the actual standards proposed. Specific details of how such consultation would be brought about were not included in the resolution. Such cooperation is already becoming effective in relation to the American Dietetic Association and the National League of Nursing Education.

Hospital Service Plans Incorporated in A.H.A. as Institutional Members

A set of 16 constitutional amendments was adopted by the house of delegates of the A.H.A. and then approved unanimously by the assembly. These amendments are designed to bring the hospital service plans into the A.H.A. and yet to give to the plans a large degree of autonomy regarding the detailed administration of their own affairs.

The amendments provide that hospital service plans that have been approved by the A.H.A. may become Type IV institutional members of the association and their executives and trustees may become personal members. The establishment of standards for annual approval of hospital service plans and the administration of the approval program are continued as functions of the trustees of the American Hospital Association.

The plans are now given a voice in the affairs of the A.H.A. through the election of three members of the one hundred members of the house of delegates by the plans themselves, and, of course, three alternates to these delegates. The number of delegates at large is reduced from 15 to 12 to allow for this change.

The affairs of the hospital service plans are to be directed by a hospital service plan commission, which will have authority to deal with all matters of interest affecting such plans as are approved by the board of trustees and are active institutional members, Type IV. All policies of the commission are embodied in administrative regulations that will be adopted by the Type IV members. All policies that affect the standards of approval for plans will be subject to the approval of the board of trustees of the American Hospital Association.

The only controversy of any kind over the proposed amendments arose over the composition of the hospital service plan commission. Guy J. Clark, at the direction of the Ohio Hospital Association, requested that the by-laws be changed to make it mandatory that the commission be composed of three hospital administrators, three plan trustees and three plan directors. The amendments already provided that no more than one member of the commission should be appointed from any one state. It was objected that this further restriction indicated lack of confidence in the judgment and intelligence of the plans and, therefore, it was voted down.

A special schedule of dues was provided for the plans ranging from a minimum of $10 per month to a maximum of $250 per month and voting strength was also given in proportion to size, ranging from one to ten votes per plan. These votes, of course, are effective only in the election of the three delegates and in other matters concerning the activities of the plans and their central office.

The dues paid in by the plans are to be deposited in a special trust fund to be administered by the hospital service plan commission. Special provisions are made as to default and delinquency in the payment of dues by the plans.

All other amendments to the by-laws were defeated. These included suggestions by the Minnesota Hospital Association that the house of delegates should meet from sixty to ninety days after the annual meeting of the association, that the nominating committee should be elected in full each year by the delegates and that the assembly be abolished.

DR. EDWARD T. THOMPSON, MRS. THOMPSON AND DAUGHTER, DONNA JEAN, MILWAUKEE

H. L. GOODLOE, HAMPTON, VA., AND FRANK GAIL, CAMDEN, N. J.

Two Hospitals Tie for First Place in National Hospital Day Awards

For the first time in the history of the National Hospital Day awards, the committee was unable to choose between two excellent entries and so decided to give both the New Haven Hospital, New Haven, Conn., and the Memorial Hospital, Casper, Wyo., first place.

Because of the difficulty of comparing the programs in cities of 15,000 people to those in large metropolitan areas, the committee requested the public education council to authorize a new classification of awards. If adopted, this means that there will be awards for the best programs in cities of less than 15,000 population, in cities of from 15,000 to 100,000 population and in cities of more than 100,000 population. It is hoped that the publicity awards may also be increased in the same manner. These awards are provided by the Parke-Davis Company.

For Cities of Less Than 15,000 Population

A.H.A. Award: Victory Hospital, Napa, Calif.

First Honorable Mention: Pauline Stearns Hospital, Ludington, Mich.

Second Honorable Mention: Hazel Hawkins Memorial Hospital, Hollister, Calif.

Third Honorable Mention: Rockingham Memorial Hospital, Harrisonburg, Va.

Publicity Award: Glenwood Community Hospital, Glenwood, Minn.

Cities of More Than 15,000 Population

A.H.A. Award: Memorial Hospital of Natrona County, Casper, Wyo., and New Haven Hospital, New Haven, Conn. (These hospitals tied for first place.)

First Honorable Mention: Huntington Memorial Hospital, Pasadena, Calif.

Second Honorable Mention: Hotel Dieu Hospital, Beaumont, Texas.

Third Honorable Mention: St. Mary's Hospital, Saginaw, Mich.

Publicity Award: Huntington Memorial Hospital, Pasadena, Calif.

City-Wide Observances

Award: Detroit.

First Honorable Mention: St. Louis.

Second Honorable Mention: Chicago.

Third Honorable Mention: Los Angeles.

State-Wide Observances

Award: Michigan.

First Honorable Mention: Rhode Island.

Second Honorable Mention: Minnesota.

Third Honorable Mention: Texas.

Committee's Report Calls for Five New Regional Assemblies

Five new regional assemblies in the hospital field are called for in a report of the committee on regional hospital assemblies, headed by Dr. Malcolm T. MacEachern.

A northwest hospital assembly would embrace Minnesota, North Dakota, South Dakota and Iowa. An eastern hospital assembly would include Maryland, New Jersey, Delaware and the District of Columbia. A central hospital assembly would consist of Ohio and Kentucky. A maritime hospital assembly for New Brunswick, Nova Scotia and Prince Edward Island and a Canadian western hospital assembly for Alberta, Saskatchewan and Manitoba were also proposed.

Because of their size, no grouping was proposed for Texas or Pennsylvania.

What Makes the Hospital Administrator a Success?

What does it take to make a successful hospital administrator? Dr. A. C. Bachmeyer, University of Chicago Clinics, answered this question at the trustee section. "It involves," he said, "a knowledge of the basic principles of medicine, nursing, social service, business organization, personnel management and labor relations, finance and accounting, purchasing, mechanical, electrical and sanitary engineering and other basic fields. It calls for personal qualifications that are encountered only in the older professions. The administrator cannot know intimately all the details of every procedure carried out in the institution, but he must know the significance and the implications of all activities."

This is only a start. With this basic knowledge the administrator must continue his education through attending institutes, refresher courses and conventions and by reading and study. Not only should he read hospital journals, but also publications in related fields. In this self-advancement he should be encouraged by his trustees if for no other reason than the selfish one that the better informed and trained he is, the better will be the general management and service of the institution.

Central Stores Is Accounting Problem

Establishment of central stores is basically an accounting and not a physical problem, according to Albert H. Scheidt, administrator of Miami Valley Hospital, Dayton, Ohio.

Don't get the idea that central stores has to be accommodated in one room, if you haven't a room available, Mr. Scheidt advised. You can control general store issues if supplies are kept in 12 or 14 little corners as long as you keep a lock on each one. The whole problem is one of accounting.

R. H. FERGUSON AND E. O. MASSMAN, BOTH OF CHICAGO

WILLIAM J. DONNELLY, PRINCETON, N. J.; DR. H. A. BLACK

Importance of Women's Aid Stressed at Lay Groups' Own Sessions

An evening session followed by a day of group meetings kept members of women's service groups busy with such matters as volunteer aids, medical social service, hospital shops, occupational and diversional therapy, and patients' libraries. These subjects, discussed generally in the morning, were studied in detail during the afternoon, with various chairmen serving as discussion leaders.

The importance of women's work in hospitals today was outlined by Mrs. Harold Stanley of New York, general chairman of the women's committees, United Hospital Fund. Speaking before the general assembly, Mrs. Stanley stressed the importance of keeping the volunteer interested and loyal, exercising complete cooperation between the auxiliary and professional workers.

"I don't think that all men make good board members," Mrs. Stanley said, "but I don't think that all women make bad board members."

The extent of fund-raising activities by women's groups serves to reveal how important is their support and what a prominent part they are destined to play in the future of voluntary hospitals. Greater, too, than the financial aid they render is the rôle they play in public relations, interpreting to the public the work of the hospital, its needs and problems. The patients' library, for example, has been designated by one administrator as his "No. 1 Good-Will Ambassador."

Sound organization of all volunteer work is essential to the success of the program, with a paid organizer and director, or with a volunteer supervisor who is qualified and able to give the necessary amount of time to the task. This fact was emphasized by various speakers. There is a tendency, too, to organize more junior groups, thus giving to the younger generation some insight into the hospital world. One hospital even reported the active interest of a group of some 45 children of 6 years of age or thereabouts that meets at the hospital once a month to cut colored papers and trimmings for tray favors and to sort safety pins.

Because of its great potentialities and also because it is among the newer projects sponsored by auxiliaries the coffee and gift shop received much attention. There is a growing number of such shops, it was revealed, many of which are rendering great service to the hospital financially, as well as from the standpoint of public and personnel relations. Such success, however, is measured by the competence of the manager. It was repeatedly brought out that the individual in charge must know food service in addition to having a knowledge of merchandising.

The patients' library can be operated on a limited budget if sufficient interest is aroused in getting donations in books. No great amount of space is required, the only requisite being adequate light and plenty of shelving. The importance of keeping books in good condition and the presence of someone in charge who has the proper understanding and tact are other points to consider in organizing a library service.

Other high spots in the program prepared by Mrs. William Berdine, president, women's auxiliary, Presbyterian Hospital, Newark, N. J., and her associates were descriptions of the Red Cross work being done in hospitals, the Canadian women's work in defense and junior league work in hospitals. An event that aroused especial interest was the presentation in color photography of case histories of medical social work, prepared under the auspices of the United Hospital Fund of New York and presented by Mrs. Philip F. Wilson, social service committee, Hospital for Special Surgery.

Intern and Nurse Shortage an Acute Problem, Dr. Winford Smith Believes

While the situation regarding interns is now satisfactory to hospitals owing to the consideration given by the Selective Service Board and the local draft boards, the situation regarding residents is still difficult, according to Dr. Winford Smith, director, Johns Hopkins Hospital, Baltimore, and chairman of the subcommittee on hospitals of the health and medical committee of the Office of Defense Health and Welfare.

"The age limit of 28 years has helped hospitals considerably," Doctor Smith stated, "but the question is, will this limit be held indefinitely. Undoubtedly we shall be obliged to manage with fewer of this group than normally. This we must expect because there is not a sufficient number of physicians in this age group to satisfy the requirements of the Army, Navy and Public Health Service and at the same time to provide a full quota for hospitals.

"We shall cooperate by pruning this group to the minimum," Doctor Smith declared. "If we continue to demand deferment for our usual number of residents we shall defeat ourselves by creating antagonism and lack of confidence."

Discussing the defense situation, Doctor Smith continued, "The need for trained nurses is and will continue to be our gravest problem." The present deficiency of nurses cannot be accounted for solely on the basis of Army, Navy and Public Health Service demands but is probably due mostly to the larger income from private duty, he contended.

Five remedies, none of them entirely satisfactory, were noted, namely, struggling along with depleted staffs, utilizing nurses' aids, lengthening the hours of duty, curtailing the number of patients and using N.Y.A. personnel.

The use of aids or attendants, either

(*Continued on page* 134)

THE REGISTRATION DESK IS A BUSY PLACE ON THE OPENING DAY

DR. FRED G. CARTER AND DR. BERT CALDWELL

MAX GEREEN, ALBION, MICH.; GRAHAM DAVIS OF BATTLE CREEK, MICH., AND C. E. WRIGHT Jr. OF PORT CHESTER, N. Y.

Cooperation With Administrators, Public Relations Discussed at Trustee Section

That there is fault on the part of both administrator and trustee when the two fail to function as efficiently as might be desired was the consensus of the trustees' section which was attended by a large audience of professional hospital workers and laymen.

"Give the board member a job to do" was the suggestion made by William Harding Jackson, president, New York Hospital. "Use his talents to the best possible advantage."

New obligations face trustees, who comprise the policy-making body of the hospital, Mr. Jackson, emphasized. "It is the hospital's responsibility," he said, "to see that all classes are taken care of."

A picture of the size of the hospital field and its growing importance was presented by Dr. Robin Buerki, dean of the school of graduate medicine and director of hospitals, University of Pennsylvania. The fact that the field ranks fifth in point of investment makes it all the more important that its trustees take their jobs seriously.

There is a growing supply of trained hospital administrators, Dr. A. C. Bachmeyer, University of Chicago Clinics, reported. "Boards of trustees should no longer consider the appointment of individuals of little training or no experience as administrators of their institutions," he said, "or the selection as one of their own number of one whose only qualifications are no job and a passing interest in the hospital."

An increasing number of hospitals are using the services of a paid worker to head their volunteer activities. This was revealed in the discussion following a talk by Mrs. Frank Vanderlip, president, New York Infirmary for Women and Children. Mrs. Vanderlip lamented the small number of women now serving on hospitals boards, although she expressed satisfaction in the fact that they are increasing. "It is humiliating," she said, "for the head of a great women's auxiliary of a hospital to go to a trustees' meeting and report but not have a voice in the formation of policies—and no vote."

Sound public relations cannot be realized by hit-and-miss methods, by independent action divorced from responsibility or authority or by the absence of a unified program. This point was brought out by Armand S. Deutsch, chairman, public relations committee, Montefiore Hospital, New York, in discussing the importance of educating the public. Public relations is now demanding recognition for what it is, *i.e.* a major adjunct of successful hospital operation, requiring specialized talent and ability.

Purchasing Agents Will Cooperate to Avoid Shortage

Hospital purchasing agents, assembled at breakfast to hear Milton J. Luce of O.P.M. and Roger Wilde, chairman of the Committee on Priorities Affecting Civilian Hospital and Medical Requirements, agreed that they would do everything they could to avoid unnecessary shortages in hospitals by avoiding "scare" buying.

The purchasing agents decided that hospitals should help one another by lending material and supplies to one another when caught short. They expressed the view that prices will probably continue to rise.

Indications of War-Time Restrictions on Materials Absent From Exhibit

Those who looked for evidences of war-time restrictions among the hospital exhibits staged in the Atlantic City Auditorium were pleasantly surprised. It was the usual comprehensive, well-dressed show, full of color, motion and light. If the crowds that paraded up and down the spacious aisles were not as large as on previous occasions they made up in enthusiasm what they lacked in numbers. Careful search failed to reveal any noticeable substitutions of metals or other materials. With patience and persistence the hospital field apparently is assured of adequate supplies.

Some 90 commercial exhibits were lined up when the doors opened officially on Monday morning. Add to these approximately 35 educational displays and it becomes evident that there was no dearth of valuable information available to every visitor.

Careful study has been given to the problem of getting food to patients while it is still hot. Food carts today are designed to convey food at its proper temperature whether hot or cold. Contagion in the nursery has likewise been a subject for serious deliberation, with the result that a bassinet is now available that is arranged and equipped to provide individualized technic. To make the life of the patient more comfortable during the convalescent period a furniture manufacturer has brought out a vanity overbed table with standard on one side only, permitting it to slide easily over the bed. It can be raised from 28½ to 44½ inches and set at all different angles.

These are but a few of the items that the well-equipped hospital will be featuring during the coming year.

Retired Nurses Must Be Introduced to Active Duty Skillfully, Mary Burr Says

Inactive graduate nurses may be the hospital's and the public's salvation both during and following the present war, thinks Mary Burr of Lincoln School for Nurses, New York.

Recruits for refresher courses for these women will come from two groups, according to Miss Burr: (1) those who feel eager in this time of national crisis to participate in the defense program and (2) those, previously retired, who from unforeseen economic pressure must resume their profession as a means of livelihood.

"The hospital has no right to utilize members of the refresher group to take the place of regular staff nurses," Miss Burr made clear to her audience. "If some service is rendered, as it will be, this must be regarded as incidental and secondary to the educative process."

These older nurses may be troubled if put into competition with their juniors lest they be outstripped, Miss Burr believes, so their own classes must be arranged for them until they demonstrate to themselves their ability to hold their own with the younger nurses. As they gain confidence they can be absorbed into short units designed for and given in conjunction with student nurses.

In nursing, a mature viewpoint and experience in living are definite professional assets too often ignored. No academic course in technical skills can take their place, Miss Burr asserts.

Once the defense emergency is over, Miss Burr hopes that refresher courses will continue for a few nurses who need to reenter the profession for economic reasons.

Accreditation Program of N.L.N.E. Formally Approved

The A.H.A. house of delegates by resolution formally approved in principle the program of accreditation of nursing schools of the National League of Nursing Education, provided the program is directed by a joint committee which is approved by the board of trustees of the American Hospital Association.

In this connection it was announced that the joint committee of the N.L.N.E. and the A.H.A. had unanimously agreed to recommend to the N.L.N.E. that a joint policy forming committee be set up to consist of three representatives of the N.L.N.E., three representatives of the A.H.A., one representative each for the American College of Surgeons, the American Medical Association, the American Nurses' Association and the National Organization of Public Health Nursing, with the president of the N.L.N.E. as an ex officio member.

School Size No Guarantee of Quality, Nursing Section Told; 800 in Attendance

Just because a school of nursing is small it need not be taken as inferior or second rate, Bernice E. Anderson, R.N., secretary-treasurer of the state board of nurse examiners of New Jersey, pointed out at the nursing section meeting. Size of school is no guarantee of quality; in fact, Miss Anderson regretted, there is no guarantee of quality in the term "graduate nurse."

Sister M. Laurentine, R.N., educational director of the nursing school at St. Francis Hospital, Pittsburgh, wondered what a certain school in a 118 bed hospital with a student body of 215 could be giving in the way of educational opportunities, even with affliations.

Regina H. Kaplan, hospital administrator at Hot Springs, Ark., lauded the superior practical experience that the small hospital affords the nurse. There in an emergency the nurse must be prepared to exercise critical judgment until a physician can be summoned; there she must know the work of not one department but all departments.

For small hospital work Miss Kaplan wants her nurses trained in small hospital schools of nursing, where routine duties include all duties and where performance of certain clinical procedures is expected of the nurse as well as of the doctor.

Lake Johnson of Lexington, Ky., reiterated Miss Kaplan's plea for continuance of small hospital schools, quoting a small town doctor in search of nurses who said: "Don't send me any orchids; this is a ragweed patch."

Evelyn M. Farrand, R.N., instructor in nursing arts and surgical nursing, Hospital of the University of Pennsylvania, gave a lucid account of the steps in the development of efficient performance of clinical procedures.

These steps include the following: (1) knowledge of the purpose of the treatment and the desirable results in relation to the patients; (2) safety of the procedure from the standpoints of patient, staff and hospital equipment; (3) economy of time, effort and materials; (4) a clear, written record of the procedure with each detail in proper sequence; (5) approval of the record by the medical, administrative and teaching staffs; (6) the necessary apparatus; (7) instruction of the graduate and student nurses; (8) supervision of the performance, and (9) revisions of the procedure as improvements seem to be necessary.

Attendance at this meeting was close to capacity of the hall, around 800. As usual at this section the audience was predominantly women.

Editor Stresses Democratic Relationship With Nurses

Some democratic principles to be used in dealing with the graduate nurse were enumerated by Helen W. Munson, assistant editor of the *American Journal of Nursing,* before the nursing section of the convention.

Mrs. Munson urged that head nurses be given opportunity to visit other hospitals, that staff nurses participate on planning committees, that staff nurses be urged to make suggestions for conserving supplies, that economic recognition be given these nurses for their interest and good work.

A staff educational program gives the general duty nurse a chance to keep abreast of the times; other means include reading professional publications, attending meetings and taking advanced study courses.

Anna Taylor, former supervisor of staff nursing education of Massachusetts General Hospital and now on the editorial staff of the *American Journal of Nursing,* further endorsed the democratic technic by urging small group conferences, semi-weekly lectures always on hospital time and efforts to make faculty and staff a working unit.

Refresher Courses Must Offer Real Educational Experience

In an effort to reassimilate some 6000 inactive nurses into hospital and private nursing service, guidance on refresher courses is being given by the National League of Nursing Education, Claribel A. Wheeler, executive secretary, told the nursing section.

"Nearly all the recruits to refresher courses in one state dropped out because of physical disabilities or lack of interest," Miss Wheeler asserted. "A thorough physical examination must be given to all these women prior to admittance to the course.

"Moreover, the experience must be made a truly educational one or there will be lack of interest. A coordinator for the program is desirable. Instruction is being given either by special instructors or by increased work by the nursing school faculty, done as a contribution to national defense."

Refresher courses are now being given in 16 states under the sponsorship of the local or state leagues, the district and state nurses' associations or the state board of nurse examiners. Some of the $1,200,000 congressional allotment for nursing education is available for selected schools giving refresher courses.

ROBERT C. PETERS, BALTIMORE; NELLIE GORGAS, MINNEAPOLIS

FLORENCE KING, ST. LOUIS, AND DR. HENRY M. POLLOCK, BOSTON

DR. J. C. HIEBERT, LEWISTON, ME.; LUCY A. POLLOCK, BROOKLINE, MASS.

A.H.A. Votes Confidence in Officers, Cooperation in Defense

(*Continued from page 65*)

between hospital and nursing groups was demonstrated and there was less tendency for each group to complain about the work of the other. Similar cordial relations with the American Dietetic Association were noted.

The code of ethics for hospitals and hospital administrators moved closer to publication.

An Inter-American Hospital Association was definitely launched amid high hopes that it would establish closer relationships among the hospital people of South, Central and North America. Individuals and hospitals in the United States are invited to join the new organization.

Need for at least 10,000 additional hospital beds in defense areas and around Army posts was revealed.

Arrangements for a retirement program for A.H.A. employes were carried nearer to completion and the committee that has been studying this subject was directed to have a plan ready for action at the next meeting of the board of trustees.

One of the most important actions of the convention was a pledge, adopted by acclamation, that the hospitals would do everything in their power to conserve equipment and supplies, would avoid excessive inventories and would cooperate as fully as possible in the nation's defense effort during the present emergency.

Hospitals were urged to differentiate between their needs and their wants, so far as supplies and equipment are concerned.

While there was still some creaking of the joints in the machinery of the house of delegates and the assembly, it worked smoothly on the whole. The president won universal commendation by the fairness and effectiveness with which he presided, especially during the more tense moments in the meeting of the house of delegates. Although the business of the house moved along expeditiously, every delegate had full opportunity to be heard.

Experiment in Sound

Push the button and listen! Every show visitor likes to take part in a demonstration, and the one staged by a manufacturer of sound insulating material proved no exception. He proceeded to push, at the same time removing a square wooden plug, first from one tube and then another. Nothing more than a muffled buzz came from the one to the left, while from the other came the unmistakable ring of an electric bell. You see, one tube was sound treated, and the other was not.

Nurse Anesthetists Step Up Production, Buy Bonds and Award Essay Prizes

Gertrude L. Fife

Meetings of the American Association of Nurse Anesthetists were particularly significant this year because of the anesthetists' consciousness of the need for help to the defense program and to civilian hospitals.

A committee under the chairmanship of Miriam G. Shupp has been studying the needs for anesthetists in civilian and Army hospitals and reports a shortage. This shortage has not reached the emergency stage but, in the event of war, it would be extremely acute.

The convention group felt that, while it was necessary to take care of the situation, it is important that present educational standards be maintained. Therefore, the organization is sponsoring a program whereby hospitals now organized to give proper training to nurses in this field will be encouraged to increase their student bodies. It already has been done in some schools and a substantial increase in the number of anesthetists should be available shortly.

The treasurer reported a substantial increase in the funds of the organization for the current year and voted that $6000 be invested in defense bonds. Sufficient funds will remain in the treasury to take care of any educational program that will be sponsored by the association.

A prize of $50 was given to the association during the year by Agatha C. Hodgins for the best papers presented by students in schools of anesthesia. First prize of $35 went to Margaret Scott, graduate of the University Hospitals of Cleveland, for her paper on "Postoperative Pulmonary Complications." Second prize of $15 was granted to Viola Mix, her subject being "Positions on the Operating Table."

Officers elected are as follows: president, Helen Lamb, Barnes Hospital, St. Louis; vice president, Rosalie McDonald, Emory University Hospital, Emory University, Ga.; treasurer, Gertrude L. Fife, University Hospital, Cleveland; trustee, Rose Donavan, Mount Sinai Hospital, Philadelphia. Agatha C. Hodgins was elected a permanent member of the board of trustees.

Exhibitors Name Officers

The Hospital Industries Association reelected George J. Hooper of Compressed Gas Corporation, Chicago, and Elmer Noelting of Faultless Caster Corporation, Evansville, Ind., as president and secretary-treasurer, respectively, at the annual meeting. Mr. Hooper and William H. Hillenbrand of Hill-Rom Company, Batesville, Ind., were named directors for three year terms.

Boston Dispensary Opens New Evening Pay Clinic

The Boston Dispensary now has an evening pay clinic to serve working people of moderate means. The admittance fee is $1, in contrast to the regular clinic admitting fee of 50 cents. In the period since its organization, it has been 95 per cent self-supporting, according to Abbie E. Dunks, assistant director of the dispensary.

Two other clinics at Boston Dispensary are self-supporting. The health, or diagnostic, clinic is one of these. It provides a complete physical examination for $7.50.

The second self-supporting unit is a consultation clinic which gives physicians of the community the benefit of a consultant service in the specialties. The fees for this work range from $5 to $10. The information gained during the consultation is not made available to the patient but is for his physician's use, Miss Dunks told the out-patient section.

Grasslands Hospital Institutes Some Satisfactory Short Cuts

At Grasslands Hospital, Valhalla, N. Y., shortage of beds has forced the hospital to perform spinal punctures in the clinic, thereby abandoning the tradition of three or four hours of bed rest following the puncture.

Dr. E. L. Harmon, director, reports that this policy is safe and satisfactory. No more headaches followed the procedure than when bed rest took place.

Another short cut has taken place in the obstetrical field. The average length of hospital stay has been reduced from one third to one half the previous period with field nurses following up the convalescence at home. Cases are judiciously selected and no additional complications seem to have developed from early discharge.

Service Takes Precedence Over Income, Majority of Hospital Pharmacists Agree

Is it feasible for a hospital of fewer than 100 beds to have a full-time pharmacist?

Chief Pharmacist I. T. Reamer of Duke Hospital, Durham, N. C., says that question must be answered individually by each hospital following a survey. The hospital of 150 beds certainly needs a full-time pharmacist, Mr. Reamer holds.

A 150 bed hospital that has three full-time pharmacists was the surprising verbal contribution of George U. Wood to the discussion of this subject at the pharmacy section.

Peralta Hospital, Oakland, Calif., of which Mr. Wood is superintendent, runs its pharmacy as it does other departments, on three shifts each twenty-four hours. The income derived from this department represents 18 per cent of the total income of the hospital.

Peralta's phenomenal pharmacy operates on a city-wide basis in competition with retail drug stores. There are direct wires connecting it with doctors' offices, which the physicians use in telephoning their prescriptions to the hospital pharmacy. Drugs are delivered to homes all over Oakland and the vicinity.

Mr. Wood asserts that proprietors of several retail drug stores have prescriptions for their own families filled at the hospital because they know that the hospital's drugs are fresher in their potency.

Dr. Jack Masur of Lebanon Hospital, New York, was the spokesman for the large group of hospital pharmacists who take exception to a set-up like Peralta's. Most of the pharmacists in attendance took the view that the hospital pharmacy should be a service rather than an income department.

Doctor Masur voiced the public's resentment against extra charges for drugs.

"The irritation caused by extra charges for drugs creates so much ill will that it more than counteracts the time and money spent by the hospital on a public relations program," Doctor Masur stated.

What Does It Cost to Equip the Small Hospital Pharmacy?

R. H. Stimson, pharmacist of Huron Road Hospital, East Cleveland, Ohio, has made the following estimates—ideal and minimal—of the costs of equipping a pharmacy in a hospital of 100 beds:

	Ideal	*Minimal*
Fixtures	$3500	$1000
Equipment	440	322
Drugs	1625	1625
Supplies	143	103

The entire sum will not necessarily be needed at the start, since the going hospital will have some drugs and supplies on hand. If a solution room is to be added, the estimated additional cost is $2500, including equipment.

The amount of space and personnel needed will depend upon whether the pharmacy is to be an income or an expense department. Approximately 400 square feet will be needed for the pharmacy proper and 200 square feet for storage.

Drug costs, of course, are going up and by the end of the year the figures given above may be much too low.

Carbon Charge Slip Described

A triplicate pull-out carbon charge slip which has been in use for nine months at Doctors Hospital, Washington, D. C., was described and its effectiveness demonstrated by its originator, H. R. Mason, in discussing control of patient charges before the administration section.

LLOYD CHADBOURNE, HERON LAKE, MINN.; L. R. FAUST, COLDWATER, MICH.

KINGSLEY ECKERT, IOWA CITY; DR. AND MRS. HERBERT T. WAGNER, RICHMOND, AND ROBERT BACHMEYER

Rate Adjustments Handled Tactfully Pay Dividends, George Meyer Finds

A gracious and understanding rate adjustment department makes for happy community relations and reasonably good collections at Children's Hospital, Boston, according to George von L. Meyer, administrator.

Neither the admitting office, the doctor nor the social service worker has anything to say about the charges in wards or out-patient department, except in an advisory capacity.

An especially trained lay personnel staffs the rate adjustment department; these persons must be gentle, human and friendly.

The problem of payment is attacked from an educational angle. The rate adjuster explains what it costs the hospital to care for the patient—$6 a day against the $3.50 regular rate. She explains that the hospital is not publicly endowed, that it must depend for support upon its patients. She makes the parents feel how vital to the hospital their support is.

"By having Tony in the hospital for the week, you will save a little on milk and some on food. A part of this you can surely give the hospital to help pay for his care," the rate adjuster tells Tony's mother.

After learning Tony's father's salary and the family situation the rate is adjusted. No outside agency is called upon to verify the truth of what the patient's parent says is the family income. The hospital has found that the percentage of chiselers is so small that it costs more to detect them than the ensuing losses amount to.

Back-yard broadcasts throughout the city keep neighbors well informed about one another's hospital rates and these over-the-fence conversations act as a check on chiseling.

"The most detrimental factor in adjusting hospital rates is politics or pull," Mr. Meyer declares. "Once we had a preference list for policemen, firemen, Mrs. Astorbilt's laundress's child and the like and to do away with it took courage. We were afraid Mrs. Astorbilt would withdraw her annual contribution to the hospital and that the politicians would make trouble. Those fears proved invalid."

Mr. Meyer appealed to the audience for help but got none on the problem of keeping patients waiting for appointments. His hospital has spread the daily load more evenly by educating the public to make appointments by mail or telephone.

Attempts at making appointments at stated intervals had to be abandoned when patients failed to show up and the staff had to stand around with nothing to do. However, the long hours of waiting cause irascible mothers and confused histories.

Boston's Children's Hospital has no barriers at its clinic doors. Once inside, patients are passed upon according to illness. Communicable disease patients are sent immediately to the communicable disease department; others, after classification, are sent to the cashier to pay their 50 cent admission fee or, if that is too high, are referred to the rate adjustment department.

Parents' Conferences Draw Attendance of 64 per Cent

How parents are drawn into the public relations web woven by the Children's Convalescent Home of Cincinnati was interestingly told by Winifred Culbertson, R.N., before the children's hospital section.

Immediately following visiting hours each Saturday, classes for parents and individual conferences with them take place. At the classes the doctors, dietitian and various child welfare workers discuss health habits, matters of discipline, nutrition and clothing. Motion pictures are used in teaching.

That the program is effective is shown by the fact that of the 70 child patients the average attendance of parents at classes is 45.

Following classes and conferences simple refreshments are furnished the parents, the children doing the serving.

Lutes Proposes That Tax Funds Care for Indigent in Voluntary Institutions

J. Dewey Lutes presented to the out-patient section a revolutionary plan wherein city governments through tax funds would pay voluntary hospitals for the care of indigent patients, freeing overcrowded city and county hospitals from all except special types of cases.

As arguments for the plan the new superintendent of Presbyterian Hospital, Chicago, Mr. Lutes, included the following: (1) would relieve overcrowding of present municipal institutions; (2) would enable social agencies to turn funds now used for the free care of indigents to other projects; (3) would allow voluntary hospitals to use their endowment funds for research and teaching; (4) would spread the cost of indigent patient care over the entire community; (5) would provide voluntary hospitals with teaching material, thus giving impetus to medical advances, and (6) would improve the teaching service to interns and residents.

Skepticism over going the full way in adopting such a plan was voiced by the paper's discussant, Frank E. Wing, director of the Boston Dispensary. Such a policy would endanger the privilege of tax exemption now enjoyed by voluntary hospitals; would discourage voluntary charity; would tend to looseness in administration and laxity in control; would interpose another authority through the necessary commissions set up, and would remove social service from the hospital, a step that he regards as disastrous. Mr. Wing, however, is not opposed to the principle of the care of the indigent through tax funds.

LEWIS CLARK AND DON C. SMELZER, PHILADELPHIA

MRS. BABETTE JENNINGS; MABEL BINNER, BOTH OF CHICAGO

Role of Medical Records in Preparedness Program Emphasized by Librarians

The rôles of the hospital, the physician and the civilian in medical preparedness were outlined by Dr. Charles H. Schlichter of Elizabeth, N. J., chairman of the committee on medical preparedness of the Medical Society of New Jersey, at the session of the American Association of Medical Record Librarians.

Following Doctor Schlichter's talk, a panel discussion was held on methods of obtaining medical records during the present emergency. The discussion was lead by Otis N. Auer, president of the New Jersey Hospital Association, and Dr. Joseph R. Morrow, medical director of Bergen County Hospital, Ridgewood, N. J.

F. Stanley Howe, director of Orange Memorial Hospital, Orange, N. J., led a round table discussion on record room problems. The future care of the patient must be based on the records of his past treatment, Mr. Howe pointed out, and it is obvious that there will be urgent need of such records in case of a widespread emergency.

To Eliminate Hoarding Supplies

To require an emergency requisition everytime the floor supply of a particular item is exhausted is red tape that could well be cut, in the opinion of Albert H. Scheidt. He recommends that supplies be delivered to the floors weekly and when there is a shortage the person be required to come after that item. This discourages hoarding, a frequent practice when there is too much red tape.

Tuberculosis Section Hears Symposium on Control of Disease Among Personnel

Maxim Pollak

In recent years the tuberculosis section has shown a steady growth in the scope of its program as well as in attendance. This year both were exceptionally good. The officers, Dr. H. McLeod Riggins of New York City, chairman, and Dr. William H. Oatway Jr., Madison, Wis., were successful in providing a program by outstanding authorities which had a wide appeal to hospital people in general.

Doctor Oatway discussed "The Development of New or Old Space for Tuberculosis Units in General Hospitals," illustrating that by ingenuity space for a tuberculosis unit can be readily found in many general hospitals. The remainder of the morning session was devoted to a symposium on the incidence and prevention of tuberculosis among hospital personnel in general and nurses and student nurses in particular.

Formal papers were presented by Dr. H. W. Hetherington and Harold L. Israel, Phipps Institute, Philadelphia; Dr. B. S. Pollak and Dr. Samuel Cohen, Hudson County Tuberculosis Hospital, N. J.; George Ornstein, Sea View and Metropolitan hospitals, New York City. Participating in the discussion were Dr. Theodore Badger, Boston City Hospital; Dr. Leopold Brahdy, New York City; C. White, National Research Council, Washington, D. C., and John Hayes, Lenox Hill Hospital, New York City.

It was amply proved by these presentations that the incidence of tuberculosis is far greater in hospital personnel, particularly nurses, than in other occupational groups of the same age and sex. It was shown that this unfavorable situation can be successfully combated by careful and systematic tuberculosis surveys among the personnel and by a search for the unsuspected cases of tuberculosis found in significant numbers in any general hospital. It was pointed out that under the occupational disease acts already in force in many states, hospital authorities shoulder a grave responsibility when tuberculosis develops among their employes and that this responsibility can be greatly minimized by the foregoing protective measures.

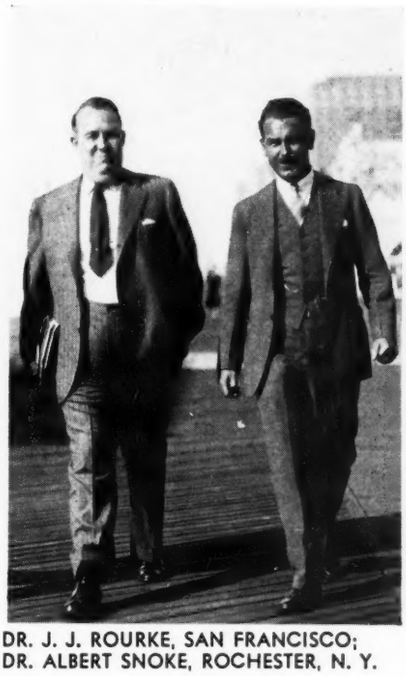
At the afternoon session formal papers were presented by Dr. Dean B. Cole, Richmond, Va., and Dr. T. B. Aycock, Baltimore, respectively, who pointed out that general hospitals must assume their responsibility in the fight against tuberculosis and that wherever this has been attempted they have played an important rôle in the combat of the disease.

A paper by Dr. L. S. Ylvisaker, Newark, N. J., associate medical director, Prudential Life Insurance Company, Dr. H. B. Kirkland and Dr. C. S. Kiessling showed how well the business interest of a large corporation is served by proper tuberculosis control measures instituted for the benefit of its employes.

The presentation by Dr. M. Pinner, Montefiore Hospital, New York City, and Dr. M. Weiss, Otisville, N. Y., gave ample evidence that the employment of arrested tuberculosis cases does not represent a significant hazard in loss of time for illness or breakdowns.

The discussants, Dr. H. H. Fellows, New York City, and Dr. F. Maurice McPhedran, Germantown Dispensary and Hospital, Philadelphia, underscored and reemphasized from their own experience the contention of the essayists.

CLINTON F. SMITH, CHICAGO; ROBERT E. NEFF, IOWA CITY



DR. J. J. ROURKE, SAN FRANCISCO; DR. ALBERT SNOKE, ROCHESTER, N. Y.

Women Aid Public Relations

"One of the most important functions of all women volunteers and one for which there is no training is public relations." To this statement made at the Trustees Section, Mrs. Frank Vanderlip, president, New York Infirmary for Women and Children, added: "Every volunteer should learn all she can about the hospital and constantly keep in mind putting its interests and its best foot forward. Those who work inside are the best possible advance agents."

One recent survey showed that $102 per active bed is tied up in supplies, Cornelia C. Pratt, purchasing agent, Orange Memorial Hospital, Orange, N. J., states.

Dietitians Discuss Reorganization of Department, Selective Menus, Cafeterias

The dietitian, like all other hospital workers, is facing new responsibilities these days. Those who attended the dietetic section at Atlantic City learned what some of these responsibilities are and how they can be met. Mary I. Barber, food consultant to the Secretary of War, and president, American Dietetic Association, and others contributed to the interesting program arranged by Lenna F. Cooper, Montefiore Hospital, New York.

Dietary departments must be reorganized, it is agreed, with fewer people doing more work. Already there is a definite shortage of experienced dietitians and personnel generally. Whether the dietitian enters the ranks of the Army or Navy or remains at home, there is defense work in which she must engage—community education in nutrition and the organization of refresher courses for those who have been inactive but who are willing to return during the present emergency. She must be prepared to accept greater responsibilities, in other words.

Those hospitals now in the course of erection or engaged in a modernization program should give serious consideration to the question of whether the special diet kitchen is necessary. Dorothy DeHart, chief dietitian, Roosevelt Hospital, New York, and Emma Baughman, Jewish Hospital of Brooklyn, N. Y., believe that it is not. Both of them speak from experience. Miss DeHart's conclusions are described on page 98.

Selective menus for ward patients may contribute to greater satisfaction but they are not practical at present with rising costs and diminished personnel. They are better adapted to those hospitals that have a central rather than a decentralized food service, according to Genevieve Coon, chief dietitian, Albany Hospital, Albany, N. Y. A recent survey among 100 hospitals revealed the fact that one or two institutions were abandoning selective menus even for private patients.

The pay cafeteria possesses many advantages for larger hospitals but is not adapted to the hospital of 100 beds or less. Both Lute Troutt, chief dietitian, University Medical Center, Indianapolis, and Mary Harrington, chief dietitian, Harper Hospital, Detroit, agreed on this point. To be successful the counter must contain a variety of foods offered at a variety of prices. The coupon system, that is, selling meal tickets, is not so satisfactory a method as making a salary adjustment. At Harper Hospital the food allowance per day ranges from $0.60 to $1.29. Catering to the low income personnel is the biggest problem.

Approve Requirements for Dietitians

Approval of the requirement that dietitians have a college degree with a major in dietetics and take at least one year of postgraduate training in hospital dietetics as recommended by the American Dietetic Association was voted by the house of delegates of the A.H.A. It was recommended that "whenever possible" hospitals employ only such dietitians, although it was recognized that owing to the present shortage of dietitians and to the limited funds available some small hospitals may have to employ dietitians that cannot meet these standards. A representative of the A.H.A. now sits as a member of the board of directors of the American Dietetic Association, thus assuring close cooperation between these two organizations, it was announced.

It Cuts Food Waste

Reducing waste in food can be effected if the dietary department is notified of any change in the patient's appetite between the time he checks his menu and the serving hour. In the early morning when the menu comes around he may be hungry and be tempted to use his pencil liberally in checking the various items. If, because of some treatment he has undergone, he has less zest for his meal, the food on his tray will be wasted. This was just one of the suggestions on reducing waste in the dietary department made by Helen C. Burns, Walter Reed General, Washington, D. C.

Show Tangible Results, Social Service Workers Are Advised

What tangible evidence of the favorable results of medical social work can the social worker give the hospital administrator so that he can sell his trustees?

The foregoing question was put to the social service section by James A. Hamilton, director of New Haven Hospital, New Haven, Conn.

Evidence that is capable of audit, research in technics and skills, these must be ferreted out by the social service department if future expansion is to take place, Mr. Hamilton advised.

Public Health Nurse Is an Asset

The motility of the public health nurse is an asset in dealing with the medical social worker, Ruth W. Hubbard, R.N., of the Visiting Nurse Society of Philadelphia, declared before the social service section. To serve her patients properly the public health nurse must be in constant association with the social service worker.

Psychiatrist Analyzes Doctor-Social Worker Relationship

The plague of defensiveness that exists in so many relationships between doctor and medical social worker is the main obstacle in the way of happier days for hospital and patients in this comparatively new field of hospital social service work.

So thinks Dr. Minna Emch, Northwestern University psychiatrist. Too often a conference between doctor and social worker becomes a field day for competitive verbal knowledges and the patient is lost somewhere in this unhappy discussion, Doctor Emch asserts.

The medical social worker is often extremely adept at not showing that she is a very human human being and the doctor must realize this characteristic.

Individualization Is Trend, Amy Green Tells Social Workers

The foremost trend in hospital administration today is individualization, Amy Green, social worker at Johns Hopkins Hospital, Baltimore, told the social service section of the convention.

Since social service work has entirely to do with the individual patient it is an evidence of the trend. Social service work must be judged by its skills rather than its speed in making transfers and in follow-up work, Miss Green declared.

The burden of proof rests with the social worker to convince the hospital administrator of the value of medical social service.

Rochester Aid Lends Dolls

Don't think those tots on the children's floor are passed by when the volunteer patients' librarian makes her rounds at Strong Memorial Hospital, Rochester, N. Y.

The younger child patients cannot select their own literature but you can be certain that they choose their dolls with nice discrimination. Susie and Billie and Shirley and all the dolls have individual wardrobes that accompany them on their visits to these bedridden foster mothers and fathers, and clothes help to make the doll.

This sideline to the patients' lending library is as profitable a piece of morale building as volunteer effort has undertaken at Strong Memorial; other Rochester hospitals recently have begun to imitate the plan.

Rubber dolls are purchased, clothes and bags are made by the volunteers, christening takes place and green cards like library cards are filled out containing the doll's name, description and itemized wardrobe.

Dolls and clothing are easily sterilized, according to Mrs. Frank R. Shumway.

Laundry Managers and Workers

—A National Study of Salaries

ALDEN B. MILLS

THE salaries of laundry managers vary over a wide range. Of 675 hospitals reporting salaries for this position, 16 pay less than $50 per month, including the value of maintenance, and, at the other extreme, 23 institutions pay $200 per month or more. The average salary for all 675 hospitals is $114.

As in the previous studies in this series, the data were collected from nongovernmental general hospitals in the United States and Canada. All figures have been adjusted to include the fair cash value of the maintenance provided. The reporting hospitals were asked to estimate this fair cash value on the basis of local conditions. Most of them did so. In the cases in which no value was given but the amount of maintenance was specified, the following values were assigned: breakfast, dinner and supper, $10 each per month; room, $10 per month; laundry, $5 per month. The total for all of the enumerated items was, therefore, $45 per month.

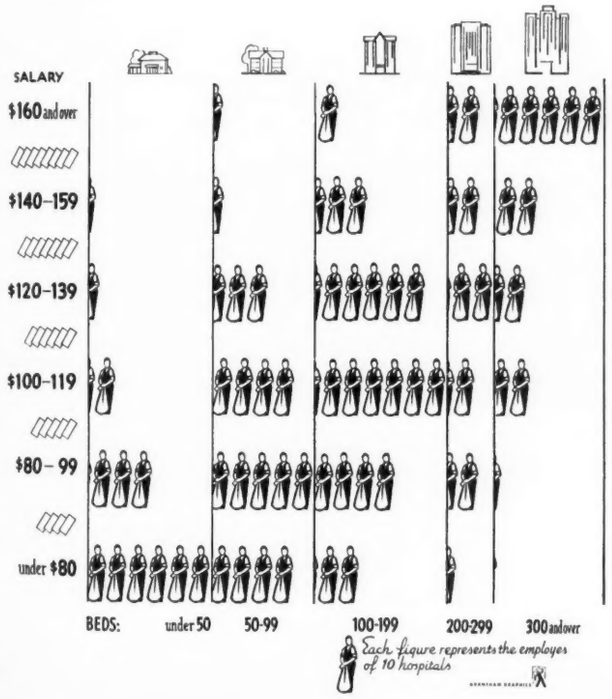
It would have been desirable to have obtained information about the hours worked, the vacations and sick leave granted, the amount of medical and hospital care provided and other items that are part of the total picture of employment conditions. However, this would have made the questionnaire too involved and complicated and inevitably would have reduced the number of responses drastically.

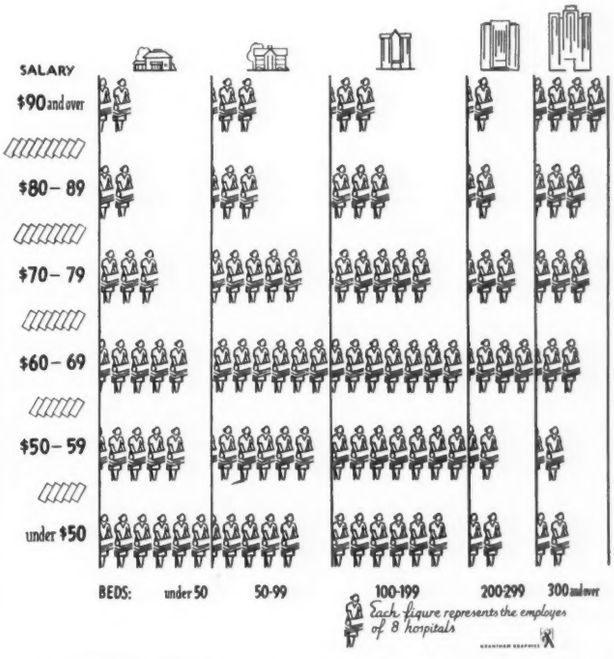
The average salary of laundry managers varies directly with the size of the hospital for which they work. In hospitals of less than 25 beds, the average salary reported was $75. In the institutions of from 25 to 49 beds, the average salary rises slightly to $79. From then on, the average salary mounts steadily with the size of the institution to reach a high of $178 in hospitals of 500 beds and more. In the Eastern states (the New England and Middle Atlantic groups), it climbs to an average of $191.

The geographic variations in salaries are not as predominantly in favor of any one area as is true in the case of some other hospital workers. In three of the seven size classifications, the Mountain and Pacific states pay the highest salaries (under 25 beds, from 100 to 199 beds and from 200 to 299 beds). In three other classes of hospitals (from 25 to 49 beds, from 300 to 499 beds and 500 beds and more) the Eastern states pay most. In one group (from 50 to 99 beds) the Southern hospitals pay the highest salaries. Except in this one group, the South paid the lowest salaries in all classes of hospitals and Canada was next to the lowest. Further details are given in the accompanying table and charts.

For laundry workers the average salary, including the value of maintenance, is $65 per month. A total of 808 hospitals submitted data for this group of employes.

A total of 154 hospitals pay their laundry workers an average of less than $50 each per month. The high-

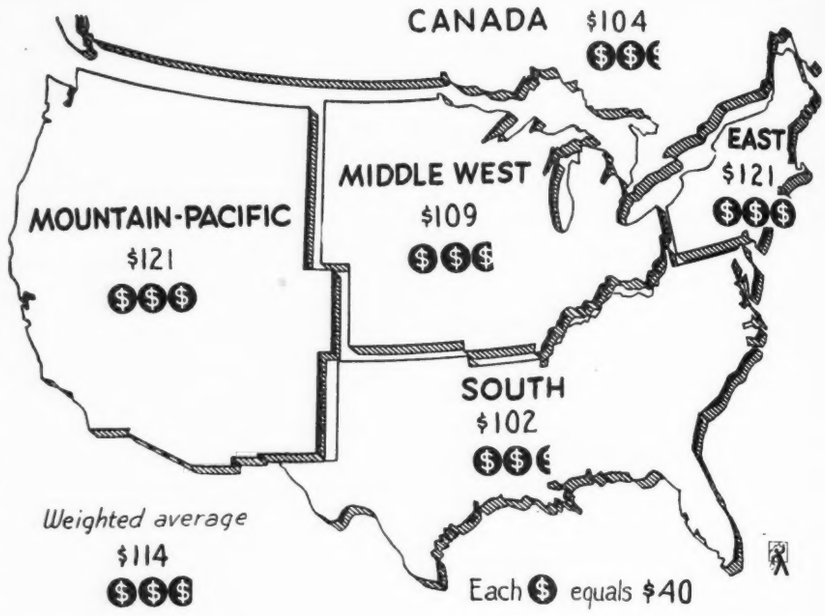




The average salary for laundry managers is $114 and the average for workers is $65, but the individual reports of 675 hospitals show a salary scale for these related groups that ranges widely above and below those figures.

est salaries reported were as follows: Eastern states, $140 to $149 (one hospital); Middle West, $120 to $129 (one hospital); South, $100 to $109 (one hospital); Mountain and Pacific states, $130 to $139 (one hospital), and Canada, $170 to $179 (one hospital). The very high figure reported from Canada is probably a mistake.

The size of hospital also influences the average salary paid to laundry workers. In the 23 institutions of less than 25 beds that reported salary figures for laundry workers, the average salary was $59. This increases step by step as we consider larger sized hospitals and reaches its peak at $83 per month in the hospitals of 500 beds and more. Curiously enough, however, in the Eastern states, the average salary in the small hospitals was higher than in institutions of medium capacity. In this area, the lowest salaries were reported from the hospitals of from 100 to 199 beds.



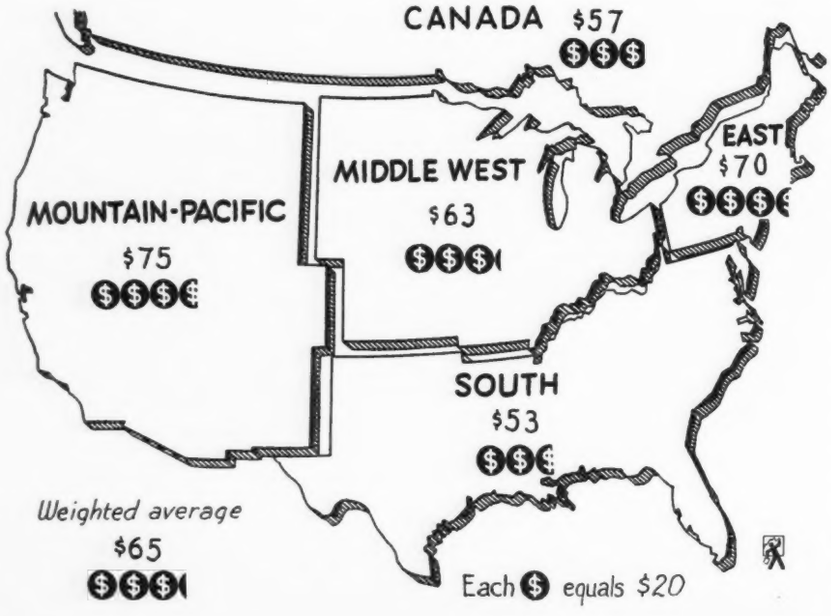
Average Monthly Salaries of Laundry Managers

	Bed Capacities of Hospitals							
Area	*Under 25*	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
East	$ 63[2]	$ 96	$ 97	$113	$131	$160	$191	$121
Middle West	76	83	98	117	129	155	170	109
South	75[1]	49	105	97	106	129	159	102
Mountain-Pacific	80	76	104	127	151	147	181	121
Canada	75[1]	66	77	104	113	145	164	104
Total	$75	$79	$98	$113	$128	$150	$178	$114

Average Monthly Salaries of Laundry Workers

East	$ 80[2]	$ 70	$ 67	$ 66	$ 69	$ 78	$ 88	$ 70
Middle West	62	60	63	62	63	65	86	63
South	46	48	59	51	52	60	48	53
Mountain-Pacific	59	61	71	83	85	84	94	75
Canada	43[2]	60	49	57	72	56	69	57
Total	$59	$61	$64	$64	$67	$70	$83	$65

[1] One report received. [2] Two reports received.



In all of the classes of hospitals of 50 beds and more the salaries in the Mountain and Pacific states are higher than in any other region. The Eastern states usually pay the next highest salaries; in the group of hospitals of less than 50 beds they are in first place. Lowest salaries are paid in the South in four classes of hospitals and in Canada in the other three classes. The Middle West occupies a half-way position in most instances, paying neither the highest nor the lowest salaries.

In many states wage laws control the minimum salaries that can be paid to the laundry employes. Such laws usually also limit the hours of work to 40 or 45 per week (or 180 to 200 per month) and set minimum wages of 25 cents to 30 cents per hour. This would give minimum monthly incomes of from $45 to $60 if the employes worked the full number of hours permitted.

The upward trend in wages of employes in the hospital laundry in recent years has directed the attention of alert administrators to the importance of modern, efficient laundry equipment. Such equipment often permits the completion of a larger amount of work per employe and thus enables the hospital to pay higher wages to a smaller number of employes.

Infection Control in the Surgery

BERTHA ELLINGSON

Operating Room Supervisor
Presbyterian Hospital, Chicago

MANY factors enter into a plan for the control of infection in the operating rooms. All, however, center in an effort to prevent pathogenic bacteria from entering the patient, particularly by way of the surgical incision.

Bacterial entrance to a surgical incision may result from contamination by direct contact or by contamination from the air. Preventive measures for infection center in the destruction of bacteria by sterilization and the establishment of meticulous cleanliness throughout the department. This also brings into use the principles of antisepsis and asepsis.

Sterilization as a Factor

For the destruction of pathogenic bacteria the most practical sterilizing agents available are thermal and chemical sterilization. Of these, thermal sterilization, through its power of penetration, is the more efficient. The most potent method of thermal sterilization is the application of heat through moisture. Since the advent of noncorrosive metals in instruments, the need for dry heat as a method of thermal sterilization has become less imperative.

To accomplish sterilization by a thermal method, adequate sterilizers should be at hand. To reach sterilization by steam under pressure careful attention should be given to the following:

1. Each sterilizer should be equipped with the devices necessary to determine its functioning, such as thermometer, pressure gauges and record and timing devices.

2. There should be frequent and intelligent inspection of sterilizing equipment. Repairs should be made immediately in order to keep equipment at the highest level of efficiency.

3. The sterilizers should be operated by persons who not only are familiar with sterilization and its problems but also have some knowledge of aseptic technic.

4. Frequent tests should be made to assure safety. These tests should be taken from points in the sterilizer where the temperature is known to be lowest, namely, the point of discharge.

5. Articles wrapped for sterilization should be covered well with a heavy, yet porous, material to permit steam to penetrate the package.

6. Packages should be placed in the autoclave on edge. Overloading should be avoided so that the steam may have free access to each package.

If water boilers are used as sterilizers, attention should be given to the chemical content of the water, the water intake and the drain. To shorten the sterilizing time, the water should be rendered alkaline by the addition of soda.[1] The line for water intake should be connected to the hot water supply and should hang outside the sterilizing chamber. This precaution will prevent contamination of the sterile load by a slow leak from a faulty valve. The drain should be broken a short distance from the boiler to prevent backwash from the sewer into the sterilizer.

Chemical Sterilization

Thermal sterilization ruins some materials. For such articles chemical sterilization with selected germicides is the only alternative. However, if the article is scrupulously clean the number of bacteria will be reduced and chemical sterilization may be used with a highly desirable margin of safety.[2]

All prepared supplies, particularly suture material used in surgery, should be obtained from reliable sources. The sterility of suture material is of paramount importance.

Sterilization is of little value in the control of infection unless it is followed by the rigid use of aseptic technic, a plan that maintains the sterility of instruments and supplies from the time they are sterilized until the operation on the patient is completed.

Establishing Aseptic Technic

The establishment of aseptic technic in the operating rooms is one of the major problems involved in the control of infection. It includes organization of routine procedures and organization and teaching of technics to a staff of workers. Efficiency in the use of aseptic technic depends much on the individual workers, their alertness and their dexterity in maneuvering throughout procedures.

To acquire skill in the use of aseptic technic, a worker must have not only a knowledge of the principles, but also a knowledge, imprinted so deeply on the mind that it becomes a subconscious part of the individual's thinking and comes into play instantly, of the details of any aseptic procedure.

Included in any staff of operating room workers there are always some members with limited experience who require much instruction, constant guidance and supervision. The number of such members should be kept at a minimum. They should not appear in the department oftener or in greater numbers than can be cared for safely by the instructors and supervisors. Supervision of the inexperienced requires eternal vigilance on the part of the supervisor until the worker has acquired the necessary skill in the use of aseptic technic.

Contamination of an aseptic field may occur by direct contact with an unsterile object or by exposure to air that may be laden in varying densities with pathogenic bacteria.[3]

Contamination by direct contact may be controlled by the rigid use of aseptic technic on the part of the operating room workers. The contamination by direct contact most

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[1]Ecker, E. E.: Are There Satisfactory Chemical Methods for the Sterilization of Instruments? Surg., Gynec. & Obst. **71**:424 (Nov.) 1940.

[2]Spaulding, Earle H.: Studies on Chemical Sterilization of Surgical Instruments, Surg., Gynec. & Obst. **69**:743 (Dec.) 1939.

[3]Kraisol, Cornelius; Cimiotti, J. Grier, and Meleny, Frank: Consideration in the Use of Ultraviolet Radiation in Operating Rooms, Ann. Surg. III:161, 1940.

difficult to control is that which may occur from a septic area directly in the surgical incision. All instruments and supplies used in and about the septic area must be isolated to prevent contamination of the entire wound.

Likewise, following an operation on a septic patient or a patient whose septic condition is localized in the region of the incision, isolation technic should be maintained in the care of all the materials contaminated during the operation until they are disinfected. Disinfection in this instance should precede thorough cleansing of the materials to avoid the spread of bacteria about the department and to protect the assisting help from the dangers of infection.

A detailed description of such a procedure is given by Dr. William C. Beck of Chicago.[4] Whenever possible, infectious operations should be placed last on the day's schedule of operations. This arrangement will give the time required for disinfection before the next operation takes place.

Bacterial Content of Air

The air as a source of contamination of a surgical incision has been given greater consideration during the last few years than previously. Contamination by exposure to the air may be materially reduced by lowering the number of pathogens in the air either by preventing their entrance to the department or by replacing at frequent intervals polluted air with clean washed air. Some authorities advocate the destruction of bacteria in the air over the surgical incision with ultraviolet ray.[5]

Clean walls, ceilings, furniture and floors will help to reduce the bacterial content of the air in a department as well as to reduce the amount of contamination by direct contact.

Pathogenic organisms may be brought to the surgical department by the patient, the department personnel, visitors or personnel or equipment from other divisions in the hospital.

To avoid entrance of bacteria into the operating rooms with the patient, patients with septic conditions or those harboring pathogens should be cared for elsewhere in the hospital, whenever possible. This applies particularly to patients with ear, nose and throat infections, genito-urinary infections, out-patients or patients with undiagnosed conditions.

Careful control of infections among members of the personnel and attention to dress in the division reduce materially the danger from this avenue of bacterial entrance to the operating rooms. Routine nose and throat cultures should be made on all members of the personnel before they are assigned to the division, with a repetition of culture whenever evidence of infection occurs. Any person carrying an infection (common cold included) should be eliminated from the personnel. Adequate face masks should be worn, carefully covering the nose and mouth while in the operating room proper, while working about the patient or about sterile materials. A cap and gown worn in the department only should cover the hair and clothes. The same precaution should be expected of visitors who enter the department. Special shoes for operating room use is another preventive measure in the fight to control infection.

Elimination of the operating rooms as a supply department for other parts of the hospital will reduce the number of bacteria brought there by the personnel and with the equipment from other departments in the hospital.

Certain routine methods of procedure in preparation for operation will reduce the time sterile instruments and supplies are exposed to either direct or indirect contamination.

Structural Aids

The location of the surgery in the hospital can do much to effect reasonable isolation of the division. The floor plan may be so arranged that visitors can enter the amphitheaters or observation benches from the floor above and thus reduce the number of persons on the operating floor. The plan should be large enough so that one unit may be reserved for septic operations, to avoid the intermingling of septic and clean operations in the surgery.

The structural plan of each unit in the operating rooms can facilitate working conditions and thereby enable the workers to use aseptic technic with ease. This convenience, in return, will avoid unnecessary exposure of sterile supplies and equipment that are used in a surgical operation.

The question of who shall assume the responsibility for the control of infection in the operating room rests with the particular hospital. The arrangement in most hospitals is as follows: (1) the structural and mechanical aids are provided by the administrative department; (2) the nursing department provides the necessary number and type of staff workers, nurses, both graduate and students, nurses' aids, orderlies and maids; (3) the responsibility of sterilization, the teaching and supervision of the staff workers in the various technics is taken by the operating room supervisor and her co-workers, and (4) advice on the nature and cause of infection is given by the surgeons and the hospital pathologist.

Individual Tolerance for Infection

Patients show a remarkable tolerance for infection. Contamination of a surgical incision does not necessarily lead to the growth of infection in the incision. The number, kind and virulence of the organisms, the resistance of the patient to infection, the type of surgery performed, each affects the growth of wound infection. If this were not true, the growth of infection in a surgical incision would be the rule.

Nevertheless, to have a growth of infection in an incision, pathogenic bacteria must be present. The most virulent of these can easily slip through to the patient and cause disastrous consequences. Therefore, no effort on the part of the hospital should be too great to safeguard the patient.

Since it is generally believed that the greater number of certain pathogens are transferred through contact contamination, too great emphasis cannot be placed on sterilization of supplies and equipment, followed by the rigid use of aseptic technic on the part of the operating room staff workers. Of all the factors that enter into the plan for control of infection in the operating rooms these two should be given the greatest consideration.

[4]Beck, William: General Operating Room Technique, Arch. Surg. 33:876 (Nov.) 1936.
[5]Hart, Deryl, and Sanger, Paul: Effect on Wound Healing of Bactericidal Ultraviolet Radiation From a Special Unit, Arch. Surg. 38:797 (May) 1939.

"Passed by the Censor"

From S. R. SPELLER, LL.B. (Lond.)
Editor, The Hospital

London, England, August 22, 1941

DEAR Colleagues in America:

The last month here in London has been entirely free from enemy air attack. Indeed, as you will probably have read in your papers, there have been few attacks on this country at all during that time as a result, no doubt, of the enemy concentrations on the Eastern front.

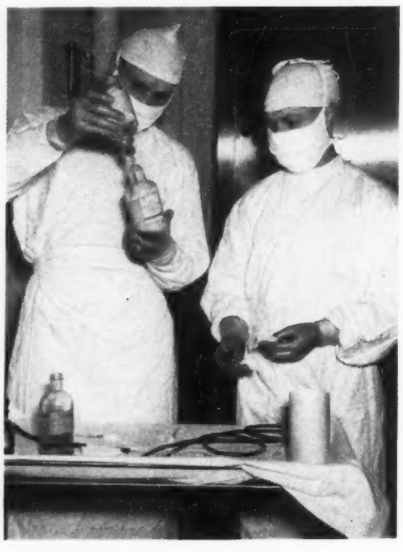
It would seem, however, that this period of quiet has been used by those concerned with our hospital and health services for clearing away administrative difficulties and for preparing the ground for peace-time developments. This is particularly true in the sphere of nursing, some of the problems of which I discussed in an earlier letter.

In April, it will be recalled, our Minister of Health announced the new scale of salaries for members of the war-time Civil Nursing Reserve as well as for probationers, *i.e.* student nurses, enrolling during the war for training at any hospital to which the minister might allot them. The effect of these revised rates of pay was to give considerably higher remuneration to trained nurses (state registered), to assistant nurses (untrained) and to this special class of probationers than their contemporaries in ordinary hospital service were receiving. As a consequence, county and other local authorities controlling public hospitals had to increase their rates of pay, as did the older, voluntary hospitals.

In the case of the voluntary hospitals, which group includes such well-known institutions as "Barts," "Guy's" and "The London," the heavy increase in expenditure involved, coupled with falling revenue from subscriptions and donations, resulted in urgent representation being made to the Minister of Health that his department should accept responsibility for the extra expenditure his decision had caused.

After barely four months' negotiations, the minister has agreed to make temporary grants to voluntary hospitals up to, roughly, 50 per cent of the cost of increases in salaries necessitated by his earlier decision, these subject to appropriate upper limits. Moreover, he has agreed that the British Hospitals Association, the association of voluntary hospitals for this country, shall act as intermediary in submitting the accounts of the hospitals and as agents for distributing the authorized grants.

Thus, the British Hospitals Association has obtained for the voluntary hospitals not only an important financial concession but also a recognition of the principle that in such matters hospitals should deal directly with the government through their own association; up to the present time any aid for those institutions has been given only through the local authority in whose area they were situated and at the discretion of the local authority concerned. The change is an important one because, although a voluntary hospital might be situated within the area of a particular local authority, its work is very often on behalf of patients coming from a much larger area. For this reason, as in the case of the London County Council, there has always been some hesitancy on the part of local authorities about using their statutory powers of making grants to the voluntary hospitals.



Dried blood plasma collected from volunteer donors is being restored to liquid form for use in the U. S. Navy. Many shipments have gone to Britain during the year.

The present arrangement with the Ministry of Health is, however, to operate only pending the findings of a national committee on nursing salaries, which will be appointed by the minister in due course and which will consist of two panels, the one representative of the employers and the other representative of the employed.

It is too early to prophesy what the findings of that committee will be, but one would not, I think, be overbold in forecasting that, following the lines of the report of the Interdepartmental Committee on Nursing Services (the Athlone Committee), which reported in 1939, the new committee will recommend that some kind of a subsidy shall be given to the voluntary hospitals to assist them in providing an adequate nursing staff.

Probably as the result of the present discussions about nursing salaries, the Royal College of Nursing has also decided to supplement the work of its present subcommittee on reconstruction by setting up a joint committee and inviting the services of representatives of other interested organizations, such as the British Hospitals Association, the British Medical Association and the Incorporated Association of Hospital Officers.

Thus, encouraged rather than hampered by the war, the problems of recruitment and training of nurses, as well as their conditions of service, are likely to be tackled within the next few months.

On the practical side of hospital work, too, there are further advances to record. For example, the great attention which, even before the war, was being paid to the subject of rehabilitation of persons injured by accidents, particularly industrial accidents, has been redoubled because of the inevitable increase in accidents as a result of the war and because of the urgent need for similar treatment for war casualties, both service and civilian.

How 17 Hospitals

Conserve Equipment and Supplies

Are you, like each of these administrators, exerting a little extra effort to economize on hospital materials? Collective cooperation in conserving supplies and equipment can mean a vast saving of resources

BECAUSE of the impending scarcities of hospital supplies and equipment, conservation of all available items is especially important. To ascertain how the average small hospital has planned or is planning to act to ward off, in some measure, a general shortage of equipment was the purpose of our questionnaire for this month.

Most of the 17 hospitals who reported on the question are taking progressive steps to avoid breakage and waste. At North Mississippi Community Hospital, Tupelo, Miss., paper plates, cups and saucers and drinking tubes are used on all trays served to isolated patients, whose dishes require special care, Helen Branham, superintendent, tells us. "This has cut down breakage and the amount of time required to care for isolated trays," she continues. "The exchange system is recommended as a measure to cut down the quantity of supplies and the amount of badly worn equipment that accumulates in cupboards."

"We use a perpetual inventory in our storeroom in order to control supplies," Edward H. Pate, business manager, Wheatley-Provident Hospital, Kansas City, Mo., reports.

Edna D. Price, superintendent, Emerson Hospital in Concord, Concord, Mass., says all breakage is reported and signed for by the person responsible for it. Supplies are distributed and controlled by one graduate nurse; waste is inspected regularly.

Innovations and changes in physical layout help solve the problem, Alice Snyder, superintendent, St. Luke's Hospital, Marquette, Mich., believes.

"Crowding and too little space for comfortable execution of duties tend to make a high percentage of breakage," Miss Snyder says. Planning a work schedule so that the less fatigued employes are on duty at the end of the day; buying equipment that is properly balanced, is of good material and has been proved successful in other institutions; deliberate and thoughtful consideration of the potential use of equipment; a knowledge of the proper use of equipment before purchasing, and educating personnel by demonstration as to the proper use and function of mechanical equipment, all help to control waste and cut down breakage, Miss Snyder has found.

At Cottage Hospital, Grosse Pointe Farms, Mich., the most effective method of conserving supplies, Mrs. Jessie P. Bernard's experience has proved, is to have broken equipment brought to the superintendent's office by the individual responsible for the breakage. Economy of supplies is urged in talks to the supervisors and to individual nurses as the opportunity presents itself.

"We employ all graduate nurses," Dr. A. R. Hatcher, superintendent of Hatcher Hospital, Wellington, Kan., reports. "When nurses accept employment they are given written instructions taken from the code book concerning the cost of hospital equipment and supplies and their care. Certain articles that are expendable are turned in and exchanged for new ones."

Sarah L. Nicholl, superintendent of Exeter Hospital, Exeter, N. H., talks to all employes and nurses regarding the necessity of conserving all supplies and they try to work out together various schemes for cutting down on supplies, dressings and laundry items.

"We have talked to the medical staff and to the employes about being careful with equipment and supplies and we are attempting to use up various items that have accumulated," Eric W. Cruser, assistant superintendent and business manager, Paul Kimball Hospital, Lakewood, N. J., writes. "We require employes to pay for supplies that are broken through carelessness."

Mrs. D. L. Rodeen of Jane C. Stormont Hospital, Topeka, Kan., requires personnel to return broken articles before new ones are issued, thus keeping a close check on supplies used.

To the question, "Do you favor the idea of charging nurses and other employes for breakage?" eleven administrators answered "Yes" and five answered "No."

Helen Branham, North Mississippi Community Hospital, Tupelo, Miss., takes an arbitrary stand. "Whether or not to charge nurses and other employes for breakage should be decided by the way in which the breakage occurs and the record of the person involved," she believes.

Other superintendents, however, feel strongly on one or the other side of the controversy. Dr. A. R. Hatcher of Wellington, Kan., whose hospital employs only graduate nurses, says: "As a rule, we consider breakage to be the result of carelessness—seldom is it accidental—and we feel that graduate nurses and other employes receiving good salaries should accept the responsibility and pay for their own carelessness. The management has enough unavoidable leakages without having to pay for the carelessness of its nurses and employes."

On the other hand, Frank E. Wing, former superintendent of Joseph H. Pratt Diagnostic Hospital,

Boston, writes: "Personally, I do not favor the idea of charging nurses and other employes for breakage because I think that breakage can be reduced to a minimum by the right kind of supervision. The irreducible minimum is something that the employe should not be charged for; it is better to have his cooperation through good will and interest than to attempt to make small savings by a penalty in case of unavoidable breakage."

Mr. Wing goes on to say, however: "This does not apply to charges made to students or others who are learning a technic. We find that the only way to protect ourselves in such cases is to charge the students for any breakage for which they are responsible."

Alice Snyder, Marquette, Mich., thinks that evident carelessness should be paid for by the culprit.

"I have always opposed charging employes for breakage," writes Mrs. Jessie P. Bernard, Detroit. "It is not conducive to good personnel relations and encourages the taking of supplies and equipment."

Sister M. Ambrosina, St. Mary's Hospital, Emporia, Kan., says, "Yes, I do favor the idea of charging for breakage because it trains employes to be more careful with the hospital's equipment."

Sarah L. Nicholl, Exeter, N. H., believes charging employes for breakage is the only way to make them realize the cost of supplies.

"We shall begin to charge nurses and other employes for breakage only when we feel there is an unusual amount of waste," Edward H. Pate, Kansas City, Mo., says. "Time and motion studies sometimes help us eliminate breakage."

Eric W. Cruser, Lakewood, N. J., feels that charging employes for breakage brings the matter more forcibly to their attention and that they are less likely to make the same mistake twice if they have been penalized originally.

"We charge only a small percentage for breakage," Mrs. D. L. Rodeen, Topeka, Kan., writes. "I do not think it helps much to charge nurses for these supplies as they cannot pay for them," she opines.

"We have charged our employes for breakage for ten years," reports Madell Motsiff, Wesley Hospital, Wadena, Minn. "We favor this because we believe it makes them more careful with our property."

"I oppose the idea," states Otis B. Birdsall, superintendent, Delray General Hospital, Detroit, "because I believe it has a tendency to promote ill feeling between management and labor."

It is almost imperative, in the present emergency when priority ratings control distribution of materials that go into the manufacture of new equipment and when the requirements for national defense narrow the hospital's purchasing power, that the life of equipment already in use be stretched to its greatest possible limit.

For prolonging the life of hospital equipment, these administrators have the following suggestions:

• Dr. A. R. Hatcher, *Hatcher Hospital, Wellington, Kan.:* Each employe is talked to at our regular personnel conferences, at which time all information available concerning the cost of hospital equipment and supplies and suggestions for conserving and prolonging the life of hospital equipment and breakage are discussed. At the same time, a sheet covering the subject is handed to each employe for future reference.

• Helen Branham, *North Mississippi Community Hospital, Tupelo, Miss.:* We find that autoclaving all rubber goods, instruments, glassware and enamelware, which are usually sterilized by boiling, prolongs the life of these articles.

• Alice Snyder, *St. Luke's Hospital, Marquette, Mich.:* All requisitions for early repairs should be encouraged and honored. An occasional "thank you" note to a department head for reporting breakage or needed repairs will work wonders. The employment of department heads (especially the housekeeper and the chief laundryman) who have a well-grounded and scientific understanding of care of equipment is helpful. Physicians, too, should be informed regarding the costs, function and use of certain equipment. Repairs should be handled by a skilled workman. There should be standard stock in each department.

• Mrs. Jessie P. Bernard, *Cottage Hospital, Grosse Pointe Farms, Mich.:* Greater stress should be laid on conserving equipment in schools of nursing.

• Edna D. Price, *Emerson Hospital in Concord, Concord, Mass.:* Rubber goods should be dried well, tubing drained and sheets rolled.

• Ruth Coon, *New Jersey Orthopaedic Hospital, Orange, N. J.:* Frequent and regular servicing of equipment and care in its use help conserve it. Periodic inspection may bring to light need for repairs.

• Sarah L. Nicholl, *Exeter Hospital, Exeter, N. H.:* We have all equipment inspected and put in order regularly.

• Edward H. Pate, *Wheatley-Provident Hospital, Kansas City, Mo.:* We have found that frequent painting, repairing and oiling add to the life of supplies. We put covers on equipment affected by dust.

• Eric W. Cruser, *Paul Kimball Hospital, Lakewood, N. J.:* Study the product and make a few simple experiments while using it to determine just how large a quantity is necessary to obtain the desired results. We find, also, that the cheapest material is not always the most economical.

• Madell Motsiff, *Wesley Hospital, Wadena, Minn.:* We list our employes and itemize their breakage. This list is then placed on the bulletin board. This method has helped to conserve equipment because employes always try to keep the slate clear.

• Otis B. Birdsall, *Delray General Hospital, Detroit:* In my opinion, the one thing that will do the most good in this respect, especially in the small hospital, is close and friendly cooperation between superintendent and the employe. A good director can get more things accomplished by personal talks with individual employes than in any other conceivable manner.

Another important method of economizing on national resources can be achieved through further standardization of hospital supplies and equipment. Hospitals can assist the national effort to save labor and materials if, when they do find it necessary to purchase, they try to order standard products and not ask for those that require special manufacturing processes.

Hospitals as Teaching Centers

THAT the voluntary hospital should function as a teaching center to the fullest extent of its means is the feeling expressed by many trustees.

In discussing this important subject, Dr. Augustus S. Knight, president, Somerset Hospital, Somerville, N. J., states: "The essential point for all of us always to keep in mind is that the primary function of our hospitals is to furnish all that they can for the welfare and comfort of their patients and that no other activities must be allowed to interfere with that welfare and comfort.

"There is no doubt that more and more, particularly in the smaller communities, the voluntary hospital is becoming the important and most helpful center of all the public health activities; in order to meet and solve the problems that are arising constantly its establishment and operation as a teaching center are necessary.

"In the larger places in which the hospitals are adjacent to and, perhaps, affiliated with medical schools, the question of giving instruction to medical students involves problems that are not met in places in which there are no medical schools. It is good to see what splendid clinical teachings and experiences the students get nowadays at the best hospitals affiliated with the best medical schools.

"For a number of years the wisdom of establishing nursing schools in hospitals of 100 beds or less has been questioned. I am much in favor of them for in this most practical way the young people being graduated from the high schools can carry along their work in or near their own communities and, after they are graduated, are available for nursing services to the community.

"Even if they marry, as many of them do soon after graduation, they bring the results of their nursing education and its influence into the homes of their neighbors and friends and into the public welfare organizations with which they are sure to be interested and affiliated. Without them the local communities would have to bring from outside centers graduate nurses who have no acquaintance or interest in local affairs and who surely would bring no such broad, constructive help to the local health needs as do those who have been trained and who do their work therein.

Public health education dispensed outside its walls and training of interns and nurses within are definite functions of the voluntary hospital, these trustees agree

"Training in those hospitals that are too small to establish and maintain complete nursing schools can be augmented by proper affiliations with larger hospitals in neighboring cities. I, personally, think that in communities of this type there are many young girls who desire to train for a nursing career but whose parents or sponsors cannot afford to furnish them with clothes and other necessities during the three years that it takes to graduate and for that reason I believe that those hospitals should willingly pay such student nurses a small stipend, something like $10 a month.

"We know that state boards of nurse examiners disapprove of this arrangement on the ground that students in other branches of learning pay for their education. However, I am acquainted with many families in which without this aid the girl simply would have to forego the nursing career and go into other paying work; furthermore, I am sure that faithful student nurses after their first six months earn decidedly more than their board, room and teaching costs. Hospitals cannot pay extravagant or wasteful salaries but they are obligated to pay with such fairness for all services as to produce a body of reasonably comfortable and contented employes in every division."

David Pender, president, Norfolk General Hospital, Norfolk, Va., agrees with Doctor Knight that the voluntary hospital should function as a teaching center but he believes that the extent of its teaching must depend largely upon the local situation.

"If there is a medical school in the city," he states, "the teaching of the general public can be left to it and its associated hospitals. In the communities in which the voluntary hospitals serve as the main source of public health information, the hospital should function extensively as a teacher of public health to the general public.

"A great deal of this teaching may be carried on in the out-patient department clinics: prenatal, postnatal, diabetic, cardiac and venereal disease. In some localities a series of public lectures given by the hospital staff to the public will serve to fulfill the hospital's teaching obligation to those members of the community who do not seek the hospital's aid as patients but to whom preventive medicine should be presented.

"The voluntary hospital, a community enterprise, must have as its objective service to the community that supports it. More and more the teaching of the prevention of disease plays a leading rôle among the services that medicine renders humanity. The voluntary hospital should in every possible way aid in the dissemination and teaching of preventive medicine to its community."

"As far as their means permit, voluntary hospitals as well as municipal hospitals should function as teaching centers." This is the opinion of John Cavanagh, president of Norwalk Hospital, Norwalk, Conn. "That does not mean," he adds,

"that a hospital heavily in debt should try to maintain educational features that would be an added burden. Hospitals, in general, owe to the communities they serve every effort to use all available means of education. This duty extends not only to doctors and nurses but also to the general public through the organization of various clinics, such as prenatal and postnatal, and through other modern methods. Only in this way can the public take advantage of up-to-date scientific study of the care of human beings.

"Health is most important. As the mother is the hope of a nation, the efforts to educate the family are more important now than ever. Give us healthy mothers, educated to take good care of their health, with the knowledge that it is their opportunity and function in life to bring healthy babies into this world of ours."

Those Trustee Meetings

ROBERT BROWN

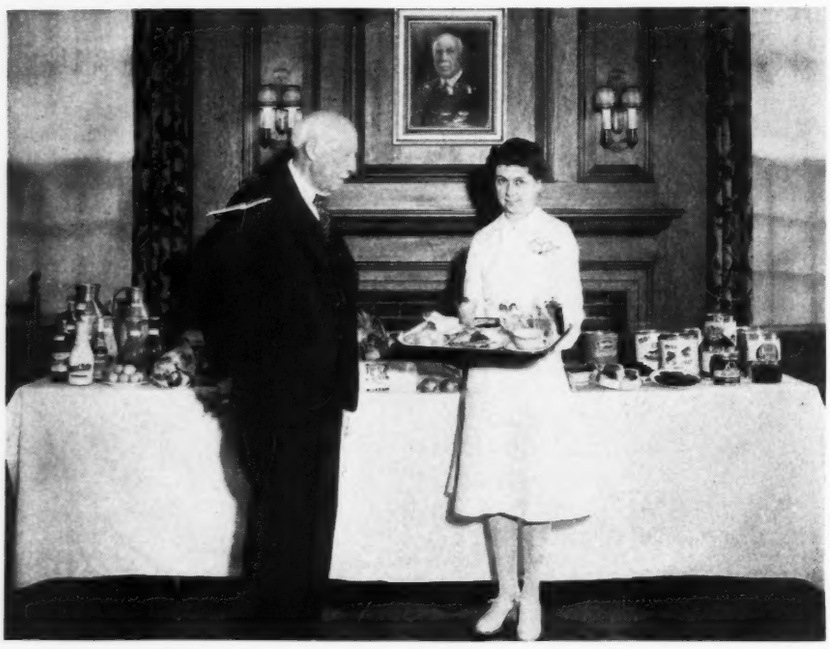
Administrator, Norwood Hospital, Norwood, Mass.

WHY not develop a program for trustee meetings that will be both interesting and educational? The same care expended on these important gatherings as on purely social events not only will solve the problem of attendance but also will give the average man and woman a different insight into hospital work.

Suppose, for instance, we were to follow the example of Norwood Hospital, Norwood, Mass., and feature at each meeting the work of one particular department. The first step at Norwood was to add a sheet of illustrations to the treasurer's report. This was called "High-Lights." It went over so well that in subsequent reports certain departments were featured and, in addition, exhibits of supplies and equipment were staged in the board room for the benefit of the trustees.

"High-Lights," incidentally, is edited in the office and produced on a duplicating machine that was purchased some time ago to produce letters in quantities. The hospital raises all its funds through appeals prepared in the hospital and duplicated on the machine.

Our first complete program was presented by the dietary department.



The first presentation in Norwood Hospital's program for interesting and educational trustee meetings was the dietary department's display showing the quality and quantity of food consumed in the institution every month.

The illustrated sheet was attached to the treasurer's report with items of gain or loss emphasized. The consumption of various commodities for one month was shown and other salient facts were illustrated by sketches. For example, a food tray bore the following caption: "Raw food to fill this tray for one meal cost 16 1/3 cents."

Tables containing foods, with the prices attached and the names of the firms supplying them, were set up. These included only samples of food served during that month. The administrator reviewed the work of the department with the assistance of the dietitian. She presented the "Trays of the Day," breakfast, dinner and supper, after which she explained the preparation and the serving of food. Many jams, jellies and preserves were opened and sampled.

As a result, our trustees, we are sure, now know the quality of food served in their hospital and understand how it is prepared. Should any criticism come to their ears, they are in a position to discuss the subject intelligently and to correct any false impressions or statements.

The next department to be thus featured was the x-ray. On the special sheet was a short history of the discovery of the roentgen-ray with figures showing the number of treatments given, the expenses involved and revenue received. A portable machine was exhibited and x-rays were taken. These films then were placed on the illuminator to show the x-ray's great value to the physician in diagnostic work. A set of films revealed the progress of a safety pin through the body of a child and the actual pin was exhibited. This film showing was supplemented by a talk by the roentgenologist.

Other similar programs are being planned around the laundry, laboratory, surgery, maternity and nursing departments.

Routine meetings of hospital trustees at which financial reports are read and discussions held, while necessary, are frequently uninteresting to many board members. These meetings can be supplemented by some plan to stimulate interest, by making it a pleasure for members to attend rather than a tedious responsibility.

"The hospital must, therefore, now gird its loins and prepare for trying times of reorganization ahead. It will justify its reputation for adaptability to changing times and requirements only if it can surmount this crisis."—Modern Hospital editorial.

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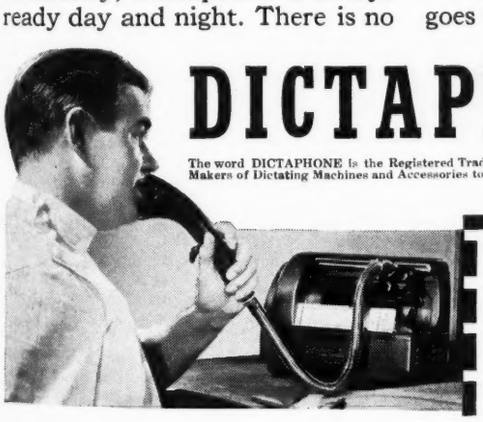

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Painting— For Preservation and Sanitation

J. M. CREWS
Assistant Superintendent
Methodist Hospital, Memphis, Tenn.

THE public is accustomed to the thought that hospitalization means ultimate restoration to health, if it is at all possible, and is accustomed to the idea that sanitation is paramount in a good hospital. It follows then that a well-kept, clean and cheerful atmosphere is generated by a clean, well-painted institution.

Little need be said about the principles behind proper painting maintenance but a great deal remains to be said about the details of a painting program. Any suggested program must be modified by the conditions at the particular institution, for such a program depends on type of construction, policy and funds.

Painting Outside Surfaces

Most modern institutions are of masonry construction. However, there are numerous outside surfaces to be protected with paint. As screens are removed in the fall, it is well to examine the condition of the outside surfaces and do such work as is necessary.

Examine all metal flashings and valleys and remove all dirt. These areas receive a great deal of wear and a coat of red iron oxide roof paint each year will keep them in good condition. If any rust appears, they should be cleaned and a coat of rust inhibitive paint, such as red lead and oil or zinc chromate-iron oxide primer, should be applied over these spots. This is called spot priming. If new valleys are installed, the whole should be washed free from grease and oil with mineral spirits or turpentine before applying the rust inhibitive primer.

Gutters should be cleaned free from the seasons' accumulation of dirt and leaves and treated as the valleys. The United States Bureau of Standards, in report B.M.S.44, has shown that when a steel or iron surface is treated with some of the proprietary phosphate chromate washes that are available the paint adheres better and longer service may be expected. The wash provides a surface that holds paint better; its primary purpose is to convert the surface of the metal to an iron phosphate and to render it passive so that it has far less tendency to corrode.

The same government report shows that for galvanized metal the use of a zinc phosphate wash is desirable. Galvanized metal is rarely painted without some surface treatment to improve the adhesion of the paint; the zinc phosphate washes that are available seem to produce the best results.

Windows. When window sash and frames are of steel, they should be examined for signs of rust and for paint failure. If either is present it should be corrected as described above.

The condition of the puttying and calking around the sash and glass should be examined and necessary repairs made. For the finish coat, a first quality house paint of selected color should be used.

Wood Sash and Frames. These should also receive the same care, especially with regard to proper puttying, as the steel sash and frames. In this case, the use of red lead paint is not necessary, since wood does not fail by corrosion.

When properly painted, wood and steel sash and frames should not need repainting every year; the service life should be about four years. However, owing to localized conditions, there may be points of weakness where some repainting and reputtying will be necessary. For this reason, examination at least once a year is desirable.

Outdoor Porches, Rails and Stairs. These should receive periodic inspection although, when properly painted, they will not need repainting any oftener than the windows. When they are painted it is well to give attention to the tops of columns, seeing that they are properly capped to prevent the entry of water into the column. Stairs and porch floors will need renewal more often because of the character of exposure and the traffic wear. If traffic wear is heavy, a coat of first quality porch and floor enamel should be applied every year.

Maintenance of Fire Escapes

Fire Escapes. Yearly inspection should be made to see that fire escapes are in sound condition and free from rust. If any rust spots are found, they should be wire brushed and treated with a phosphate chromate wash. After this treatment, a coat of red lead paint or zinc chromate rust inhibitive primer should be applied followed, after drying, with a coat of the finish coat paint. Some painters advocate the use of graphite paint on fire escapes, but if proper rust inhibitive primers are used the escapes can be painted in any color desired and they will not need repainting oftener than any other outdoor surface. However, it should be remembered that steel work, such as fire escapes, provides many places where water and dirt can rest; as a consequence, rust is likely to start. It is well, therefore, to inspect the escapes at least once a year and to spot paint the areas where rust may have occurred.

Lawn Furniture. When outdoor recreation and rest are provided for ambulant patients, staff maintenance of outdoor furniture is necessary. This work is best done in the late winter. The furniture should be washed to free it from all dust, dirt

and grease and, at the same time, any necessary repair work should be done. If the article is in good condition, it should be lightly sanded with fine sandpaper or steel wool and then refinished with the same type of finish. Rustic hickory furniture should be protected by a coat of good spar varnish so as to prevent the bark from coming loose.

Screens. Screens should be well washed and properly repaired before painting. This work is best done in the latter part of the winter. If finished in black, a coat of high grade black enamel should be applied. Although a thin paint is easy to apply to screens and is not likely to clog the mesh, better service is obtained if the enamel is not thinned out and is well brushed on the screened wire.

Halls and Stairways. These should be painted in light, cheerful colors. Light ivory ceiling and light cream sidewall with a buff dado is a favorite combination. A semigloss finish has been found satisfactory. Semigloss paints are more easily washed than are flat paints. For the dado, which receives more wear, a gloss wall paint is preferred. An alternative combination is a light sea green with cream dado. The ceiling may be white with just enough of the sidewall color added to tint it faintly and thus to prevent too harsh a contrast. Stairways may receive the same treatment as the halls.

Rooms and Wards. These are best painted with flat paints or eggshell finish. Gloss or semigloss finishes should be avoided as they are likely to cause "glary" effects owing to the character of the light reflection. Stippling the final coat softens the finish. If some relief from the monotony of a single color is desired, it is easy to stencil a simple border or to apply a final coat of a slightly different color and stipple so as to allow minute portions of the undercoat to show through.

Diet Kitchens and Service Rooms. These are best maintained with a high grade white enamel finish, which is easy to wash and to maintain.

Operating Rooms and Laboratories. Many of these rooms are now finished in vitreous tile, but in some cases older rooms have plastered walls. The general practice is to finish them in a high-grade gloss white enamel. The enamel should be a high-grade hard drying material that can be readily cleaned.

Sun Porches. Many sun porches are finished with plastered walls and ceilings. The finish can follow the same scheme as the walls, but since the light is good light greens of a somewhat deeper tone than used in the halls will be found both cheerful and restful. If the floors are of cement finish, they are best maintained with a high-grade cement floor enamel.

Laundry and Other Service Rooms. Usually, such rooms are located in the basement or in the service buildings. For the walls and ceilings, the use of a high-grade white enamel of the mill white type is the most serviceable. The equipment can be finished in a light gray with a water resisting enamel.

Woodwork. Most woodwork is finished by staining, filling and varnishing so that for proper maintenance only occasional cleaning is needed. The woodwork can be cleaned lightly with fine sandpaper, after which a coat of first quality interior finish should be applied.

Beds and Furniture. Metal beds and furniture should be finished in enamel, as such a finish is readily cleaned. If a separate paint shop is available, the installation of a modern spray booth and spray gun will simplify refinishing work of this nature. Here we might borrow from the experience of the hotels, many of which install equipment for this purpose. Wooden furniture can be refinished in such a shop with little trouble and expense.

Pipes and Conduits. It is my belief that pipes and conduits, when exposed, should be painted the same color as the ceiling or sidewall on which they are suspended. To identify them readily, they should be marked at suitable intervals with a properly coded symbol, preferably in color. As an example, fire control equipment should be marked in red, electrical equipment in yellow, water lines in blue and steam lines in green.

For convenience and control of inside painting, the various rooms should be classified. A suggested classification might be as follows:

Class A: Operating rooms, laboratories, diet kitchens, nursery to be repainted annually, since danger of contamination is greatest in these rooms and since sanitation and appearance requirements are greatest.

Class B: Reception rooms, rooms and wards are next in importance and, when possible, should be refinished annually. They should be washed clean at least once each year and repainted not less than every two years.

Class C: Halls, service rooms, pharmacy, stairways, interns', nurses' and doctors' rooms and locker rooms should be washed at least once each year; the painting schedule should include this group once every two or three years, according to requirements and appearance.

Class D: Laundry, boiler rooms and similar rooms can be gone over once a year for cleaning and can be repainted on a three to four year schedule as required.

Class E: Floors. Wooden floors in reception and receiving rooms can be maintained by varnishing or waxing. If they are waxed, the traffic wear should be repaired monthly. A few minutes' work each month will keep them in good condition.

In regard to materials, the old adage still applies: "The best is the cheapest." Many paint troubles arise from the short-sighted policy of buying materials that are cheaper in price, claimed to be "just as good." This is particularly true of wall paints for interior use. With cheap material, the result of the painting is doubtful, the cost of application is higher and the need for renewal occurs earlier. It may then be necessary to do a great deal of renewing of unsatisfactory material or to apply two or three coats of material to restore the surface to a proper condition. The old rule of dealing with a reliable concern in whose advice and service one can place confidence is a good rule for paint requirements.

Of late, some of the leading paint companies have placed on the market wall finishes based on the same type of synthetic resin as is used in finishing the new electric refrigerators. These products are far more durable and sanitary than the older finishes on the market. Not only do they retain their color better but they are more easily washed and less easily marred than other finishes.

The painting program plays a large part in not only the appearance but also the reputation of a hospital.

— instead of BLACKOUTS!

Today there is a World whose darkness ends not with the dawn. A World cringing underground — groping blindly through darkened streets — seeing God's daylight obscured with the dust and smoke of many explosions. A World fighting, not only invasion but the epidemics, hysteria and famine that convoy invasion.

Family life has become disrupted in the great metropolitan areas—mothers separated from children—sweethearts torn apart—and minds, now young, will carry the mark and memory of horror to their graves. It's not a "pretty" picture of Civilization 1941 Model, but one which has been painted with the brush of insanity from the pallette of War, whose colors of Blood Red, Black Anger, Disease Green, Ruin Brown and Purple Despair have never painted a light, clean picture.

Patience, though, World! The Four Blasphemies that are riding their despicable steeds through the Heavens of today will soon tire—their mounts stumble and once again the Lights of Learning—Health—Happiness and Cleanliness will shine brighter than ever before because of the lesson taught and by virtue of its very contrast.

We, here in America, have escaped all this so far. There have been no raids, no blackouts—that is, literally speaking. A gradual blackout is enveloping us, however. That is the blackout of Sanitation. Manpower is being drafted from all levels of life, and those left behind find themselves with double tasks to do, which means doing each one just half so well.

More than ever before your Custodial Department needs the aid of faster-acting cleaners, more thorough soaps and better maintenance machines. Disinfection of Schools, Hospitals and other institutions is of greater importance than ever before. There is work to be done! Do your part by giving your maintenance men the extra help that MIDLAND PRODUCTS can give.

Grant us permission to have that Emissary of Better Maintenance, the Midland Representative, call on you and outline the "MIDLAND WAY" to greater institutional cleanliness.

Let there be Light!

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Dubuque, Iowa, U. S. A.

Teaching on the Floors

DOROTHY DeHART

Dietitian, Roosevelt Hospital, New York City

IN 1935, at Roosevelt Hospital, New York City, a plan was devised whereby the student nurses would be taught diet therapy directly in connection with the patients. At that time they were spending eight weeks in the diet kitchen, visiting patients only at intervals, and there was no correlation of tray service with the special diets they were preparing. Except for a case study, they did not follow the progress of the special diet patients.

The diet kitchen was on the first floor of one of four buildings; to the right was the ward building; to the left, the administration building with the main kitchen in the basement, and, beyond this, the private pavilion. All meats and vegetables were cooked in the main kitchen and taken to the diet kitchen to be weighed and portioned. This necessitated double handling. The food was put into individual containers, which were heated upon arrival on the floors.

The plan proposed was to put the nurses directly on the wards to do the actual planning, ordering, serving and follow-up work under supervision of the dietitian. This would give them more responsibility and would allow them to see the completed trays. It would also give the nurses information regarding their own patients, which is important from the interest standpoint if for no other reason. Such a setup would require the presence of a dietitian on the ward at all times. Thus, the doctors and nurses would have the advantage of obtaining firsthand information when they needed it.

It was planned that the nurse would weigh all the food for her special trays directly on the floors. The food would come from the main kitchen in heated food trucks and that which could not be obtained from the general or soft menu would be especially ordered but would still come up in the truck with the other food.

This plan, placing special diet nurses on the wards, was instituted primarily for educational purposes but it proved to be financially successful as well

This plan had to be set aside at the time but in 1940, when the building housing the diet kitchen had to be torn down to make way for a new building project, we had to decide where to put the diet kitchen. So the old plan was brought out of hiding and we decided to give it a trial.

The dietitian's office was put in the ward building and four student nurses were assigned as diet nurses to cover the ward floors. Through the cooperation of the training school this quota is kept at four at all times. When one of the diet nurses is sick, a substitute is sent in her place. This is necessary when the work is thus divided.

The problem of serving special diets has been partly solved by having the diets more or less concentrated on the medical floors, with only a few on the surgical floors. The charge nurses or their assistants, who were formerly responsible for serving trays, continue to carry on this duty. The student nurse sets up and serves the special diets only and these are checked by the dietitian or head nurse.

Special diets are made out one day in advance by the student nurse and are checked by the dietitian. Three times a week the nurse requisitions the staple supplies for the pantries. She observes the return on trays and charts notes for the doctor; she visits her patients; has three group conferences a week with the dietitian and makes rounds with the doctors.

Any foods that require special attention are taken care of by the special order cook; otherwise, the baker's helper prepares all the gelatin, junket, custards and special desserts. The vegetable cook prepares the salt free items or special vegetables while the salad man takes care of the salads.

The dietitian on the private pavilion assists in checking trays on the wards at mealtime since the private floors are served one hour later. Then, too, there are fewer private special diets.

This change has been greatly beneficial to nurses and to patients as well. The students are enthusiastic in their praise of the new method of handling special diets and the benefits they feel they derive.

In some hospitals such a plan may seem impossible but with cooperation, a little hard work and persistence it is worth while trying to accomplish. It presupposes, of course, a dietitian in charge of the main kitchen.

While the plan originated for the benefit of the student nurses, it finally ended with an added saving in money to the hospital. Under the old system a maid, a truck boy and one or two aids were required to handle the work in the diet kitchen. Now by adding one special order cook to the main kitchen staff, we have eliminated all of these.

A saving in food, utensils, wax paper, extra containers for transporting the food individually, china and silver has resulted. And it is not difficult to imagine the saving in floor space, large equipment, gas, electricity, refrigeration, sinks and stoves. One factor we do know, that we had several thousand dollars to spend elsewhere in our new building when we told the architects to omit the allowance for a diet kitchen.

Less Waste in the Cafeteria

MARGARITA MOOS

Dietitian, Veterans Administration Facility
Albuquerque, N. M.

ALTHOUGH cafeterias have been in common use for a comparatively short time, they have played an important part in food service during the last twenty-five or thirty years.

This type of service began with the idea of serving a greater number of people in a shorter length of time and at a minimum of expense. Some administrators active in cafeteria food service have lost sight of this primary purpose. Regardless of the type of cafeteria one is managing, from a commercial cafeteria to a school lunchroom, it is essential to keep this purpose in mind at all times.

Concerning the prevention of waste in cafeteria service, there are a number of points to which otherwise able administrators fail to give adequate attention.

First, what group are you feeding? Have you considered the race and religion of your patrons? Are you serving laborers from an Italian district in New York or is your cafeteria located in the great Southwest where you have Spanish speaking people who are predominantly Catholic?

In the ideal situation we should not have to contend with racial food preference and in time we may approach this ideal, but thus far we have not reached it and it is folly to ignore the facts.

Consider the Age Group

The age group you are feeding is of equal importance; a group of women stopping for lunch before a game of bridge or golf will not be impressed by peanut butter sandwiches and lemonade, while children in third grade will think these a wonderful start for a picnic lunch.

The hospital that is serving the medical staff, nurses, employes and perhaps ambulatory patients is likely to have a wide variation in food preferences. A careful study of the food consumed and the waste will aid in future menu planning. There was the Jewish hospital that employed both Jews and Gentiles. On Good Friday a tray of matzoth and one of hot cross buns appeared on the cafeteria counter. This is one way to have a satisfied personnel, and a satisfied personnel is an asset to the institution and to you. Moreover, it will cut down food waste.

In menu planning occasionally give vent to those terrific brain storms you may have. You won't regret it. Perhaps fresh raspberries are expensive, but if you can disguise the lowly cornstarch pudding you may be ahead of the game. A small amount of some popular and unusual food can add zest to ordinary fare. It will increase appetite appeal, thus decreasing food waste considerably.

Food Can Be Made Attractive

In menu planning, however, every day cannot be Sunday. One must put into practice her knowledge of the principles involved in the procedures of food preparation. Those simple and ordinary foods that must appear on the cafeteria counter regularly might just as well, if not better, appear there attractively. Nothing is less appealing to the appetite than spinach that has turned a deadly drab olive color or cabbage that has been cooked to within an inch of its life and appears strong and brown. These are the things that are easily remedied and can really cut the food waste to a minimum.

Does the chef know how to get the most out of meat? Have you made a study with him to find the method of cooking roasts that gives the least shrinkage? The time and temperature, the character of the meat and the method of cooking must be considered. If meat is well cooked, never fear; it will be eaten.

Could you, by chance, have become used to seeing the vegetables on your steam table cut in odd sized pieces? Vegetables look more attractive if they are uniformly cut. The same is true of meats. A carver who whittles a roast instead of carving should be given instructions and detailed instructions. You are bound to have waste if you serve scrappy meat. A man who really knows how to carve can get many more servings from a roast and have them much better looking.

Some foods are not suited to cafeteria service; puff omelets and soufflés, for example. In planning the menu, foods that lose their palatability and attractive appearance rapidly must be omitted. Cooking in small quantities can help this situation and using the steam table as a point of service rather than as a storage space will help. Still, there are a few foods that just won't sell and are bound to mean excess waste.

Have you standardized your servings? The capacity of every food container should be known. When a pan containing 30 servings is placed in the steam table for service, a count should be made to see that exactly that number of servings has been made. Unduly large servings will mean waste and also will make it virtually impossible to keep an accurate record of the food cost per serving. A counter is being used in many institutions to aid in the control of food yield.

Employes Eliminate Waste

Have you trained your employes properly? Since the efficient use of labor is essential for any well-run establishment, you must consider it also in the management of a cafeteria. For your own satisfaction, start some morning to check on the usable food discarded in garbage cans. It is quite possible that you will be astounded at this source of waste.

Teach your employes the most efficient method of cleaning fruits and vegetables and check frequently to see that these methods are used. Also instruct employes in the economical use of left-overs so that they will know when and how to use them according to your menu plan.

Perhaps it is beside the point to mention the use of labor-saving devices. In most instances these rapidly pay for themselves. Not

only are many of them valuable as time-savers, but there is a decrease in the food waste when they are employed. They are planned to do the work most efficiently while employes may not have the skill or the industry to do as well.

Recently we have found a means of cutting down on wasted bread. In our employes' cafeteria we tried putting plates of bread on the tables. This was unsatisfactory. We also tried having an open loaf on the counter so the employes could take what they wanted. They almost invariably took more than they could eat. We finally struck upon the use of glassine bags. Most of the employes take just one slice of bread and it is usually all eaten.

Any type of food service is inefficient if the very most is not being obtained for the time and money expended. These suggestions cover in a most general sort of way the daily problems of a cafeteria.

RECIPES BY REQUEST

Bakeless Fruit Cake

½ pound graham crackers, rolled fine
½ pound marshmallows, quartered
½ pound dates, cut fine
½ pound chopped nut meats
½ cup thin cream
10 chopped maraschino cherries

Mix ingredients thoroughly and press firmly into a pound bread tin lined with waxed paper, which has been oiled. Let stand overnight in refrigerator. Turn out, slice and serve with whipped cream.

Apricot Wedge

20 desserts which will cut in 6 servings each

Filling:

Cook together the following ingredients until a smooth paste is obtained and let cool while preparing the dough:

6 No. 2½ cans apricots, drained
6 dates, cut fine
3 cups brown sugar
1½ cups butter
2 teaspoons salt
3 teaspoons vanilla
¾ cup apricot juice

Dough:

2½ cups butter
5 cups sugar
5 eggs
1¾ cups cream
13 cups flour
5 tablespoons baking powder
2½ teaspoons salt
5 teaspoons vanilla

Cream butter, add sugar and well-beaten eggs. Sift together dry ingredients and add to butter mixture alternately with cream. Roll to fit bottom of pie tin; layer should be thicker than for cookies. Spread ¼ inch of filling on layer and cover with another layer of dough. Bake. Cut in wedge-shaped pieces and serve with whipped cream.

Bohemian Pineapple Salad

10 pounds cabbage, chilled and shredded
1 gallon diced pineapple, chilled
1½ pounds marshmallows, quartered
1 cup sugar
Salt to taste

Toss together and fold in the following dressing:

2 cups vinegar
2 cups sugar
12 eggs
1 teaspoon dry mustard
Salt to taste

Boil vinegar and sugar to a syrup. Beat eggs and add small amount of syrup, then pour egg mixture into remaining syrup and cook in double boiler until thick, stirring constantly. Whipped cream may be added if desired.

Celery Creole

100 Servings

12½ quarts celery, cut in 1 inch pieces
4 quarts strained tomatoes
4 tablespoons salt
1 pound butter
2 cups green pepper, cut fine
2 cups onion, cut fine

Place celery and tomatoes in saucepan, add salt and cook slowly until celery is tender. Melt butter, add green pepper and onion and brown. Add celery and tomatoes to pepper and onion. Stir well and serve.

Lime Ice With Whipped Cream

1 pint whipping cream
1 tablespoon sugar
¼ cup ginger, cut in small pieces
1 teaspoon vanilla
1 gallon lime ice

Whip cream until stiff. Add sugar, vanilla and ginger. (One half cup chopped pecans may be added to whipped cream.) Place a tablespoon of this mixture on each serving of lime ice and garnish with a maraschino cherry.

NOTE: Lime ice may be made in the same way as orange or lemon sherbet, making an allowance for a little more sugar or less lime juice. Green coloring should be added.

Grape Bavarian Cream

100 Servings

18 tablespoons granulated gelatin
3 cups cold water
27 egg whites
3 cups boiling water
Juice of 3 lemons
1 cup orange juice
9 cups sugar
9 cups grape juice
1 quart cream, whipped

Soften gelatin in cold water and dissolve in boiling water. Add other liquids and sugar. Allow to congeal. Whip. Add beaten egg whites and then fold in whipped cream. Beat until thoroughly blended. Mold.

Volcano Potatoes

Prepare mashed potatoes in usual manner. Shape into irregular cones, 3 inches high. Make a deep dent in the top of each and fill with 2 tablespoons grated cheese, well seasoned. Sprinkle cheese down the sides. Bake in hot oven for 10 minutes.

Baked Tomatoes

35 or 40 Servings

1 No. 10 can tomatoes
1 cup flour
1½ cups stewed, chopped celery
½ teaspoon celery seed
¼ cup sugar
1 tablespoon salt
1¾ quarts toasted stale bread crumbs
¼ pound butter

To the tomatoes add a paste made of the flour mixed with ¾ quart of the juice from the tomatoes, stewed chopped celery, celery seed, sugar and salt. Spread in baking pan and sprinkle with bread crumbs. Dot with butter and bake in a 450° F. oven for 35 minutes.

Sprutters

150 Cookies

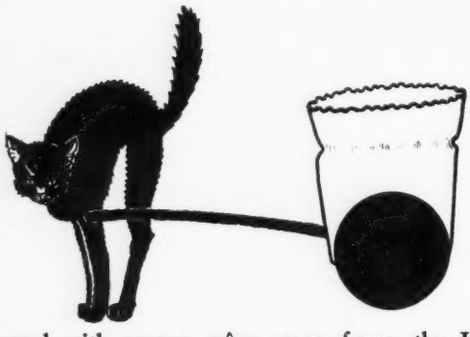
1½ cups sugar
2 cups butter
3 eggs, well beaten
6 cups flour
1 teaspoon vanilla

Cream butter and sugar. Add beaten eggs, flour and vanilla. Set dough in refrigerator for half an hour before using. Shape with sprutter cookie press. Bake in a hot oven until a golden brown.

HOLIDAY TRAY DECORATIONS

Suggested by New Jersey Dietetic Association

Left: This Idaho potato with face painted red, masked in black crêpe paper, is set in a nut cup covered with a lace doily and lined with a ruff of orange crêpe paper.



A soufflé cup covered with orange crêpe paper forms the Halloween cart and a circle of black cardboard, 1 inch in diameter, makes the wheel. A paper seal black cat (2½ inches high), pasted on heavy paper, is hitched to the cart by a 2¾ inch pipe cleaner, dyed black.

Right: Making this favor requires: circle (2½ inches diameter), orange cardboard; tripod, orange wire, 6 inch lengths, topped with cat seal; bow, black ribbon, 12 inches; kettle, black soufflé cup hung with orange wire; fire, orange crêpe paper strips.

Left: Mounted on a 2 inch wooden button, the cat's head lollypop is set off by a ruff of orange crêpe paper. Fringe is made of black crêpe paper.

Left: Lollypop dressed in orange skirt (4 by 18 inches) and rakish black crêpe paper hat, 3 inches high. Belt and arms are a continuous piece of white pipe cleaner. The base is a large black gum drop.

Left: To make the witch's tripod, paint three applicators black and tie them near the top with orange cellophane ribbon. On a soufflé cup, covered with orange crêpe paper, attach black witch silhouette, 3 inches high. Place the cup under tripod.

Right: A 2 inch soufflé cup filled with candy and covered with cellophane forms the foundation of this lollypop favor. The lollypop is inserted upright in the cup and both are swathed in black cellophane, on which a skull and crossbones sticker has been pasted.

FOOD FOR THOUGHT

Retaining Vitamin C in Parsnips

• Parsnips boiled in pans of enamel or glass retain more of their vitamin C content than parsnips boiled in aluminum and steel pans, say E. Josephine Brown and Faith Fenton of the New York State College of Home Economics at Cornell University.

The parsnips used in the research were of the Hollow Crown variety and were found to vary in vitamin C content from parsnip to parsnip. The vitamin content remained constant in parsnips from November to February but decreased suddenly during February and early March.

The percentage of vitamin C retained in parsnips cut in small pieces during the boiling was 86, during steaming, 83, and during cooking, 90. The longer the parsnips were cooked, the greater the loss of the vitamin, Miss Brown reports.

Parsnips boiled whole and unpeeled retained 95 per cent of the vitamin; peeled and cut in pieces, 81, and sliced, 84.

As It's Done at Hackensack

• In Hackensack Hospital, Hackensack, N. J., 120,720 trays were served during the past year to private and semiprivate patients by a system in which the maids served the food, with a dietitian checking each tray before it was carried by the floor maid or the dietary maid to the patient.

Elizabeth Rupert, the dietitian, reports that private patients were given linen tray covers and napkins while the semiprivate patients were given paper ones. This was the only distinction in the food service to these two types of patients. Private and semiprivate patients both received menus and were visited daily by a dietitian.

In the same period 154,998 trays were served to the ward patients. For this service the dietitian in charge had under her supervision six student nurses for a period of six weeks, who were trained to serve the trays in the surgical, medical and children's wards.

During the two and one half years of this type of service it has been observed that the patient is better pleased as his trays are more closely supervised, he is visited daily and his likes are catered to. The student nurse has a greater interest in her diet kitchen experience for she is assigned to that specific job for six weeks and it is her duty to see that every patient on her floor is satisfied whether he is on a special diet or on a regular diet.

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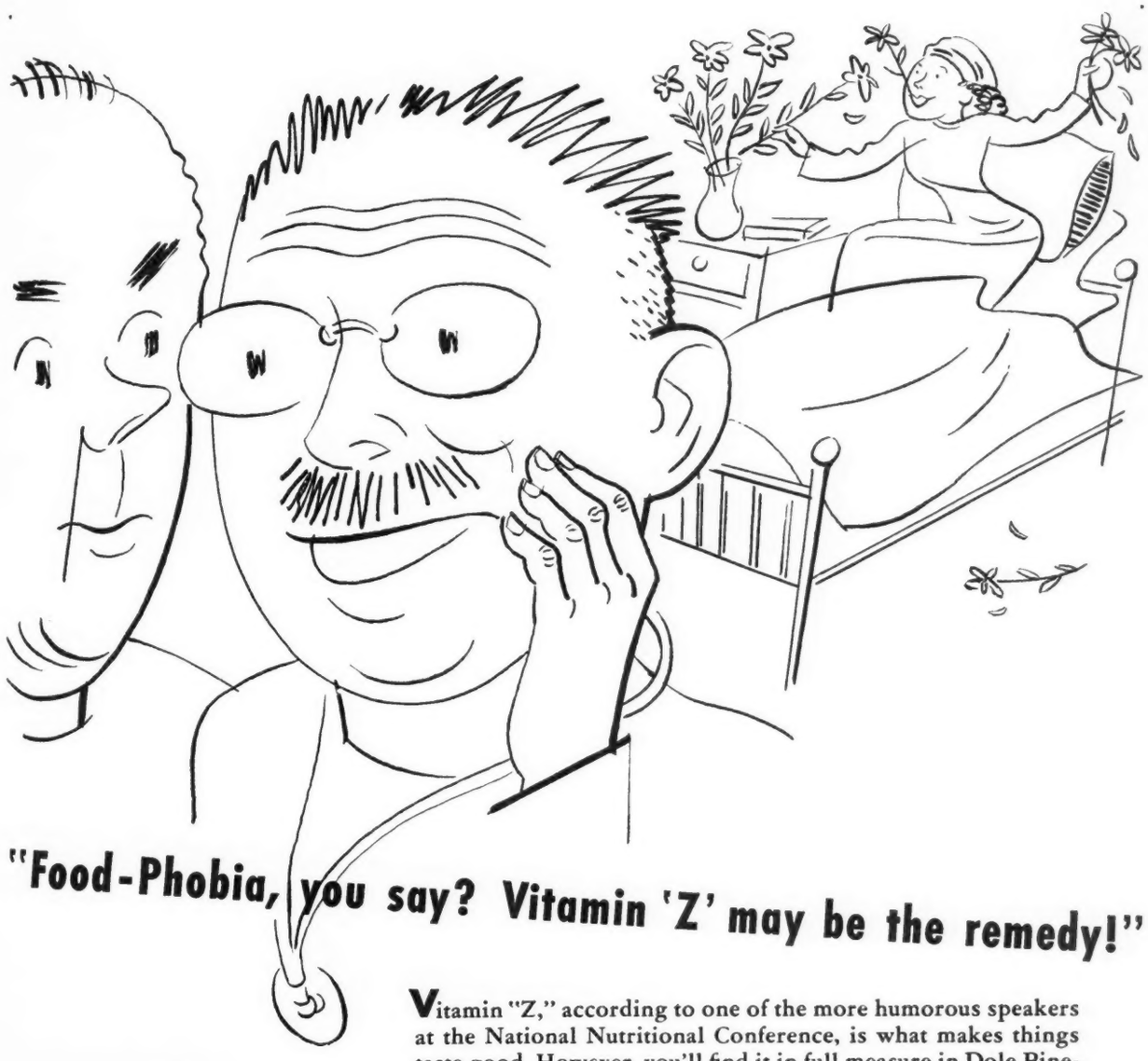
November Dinner Menus for the Small Hospital

Ruth Hawkins

Dietitian, St. Francis Sanitarium, Monroe, La.

Day	Soup or Appetizer	Meat or Fish	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Cream of Tomato Soup	Baked Halibut	Buttered Potatoes	Buttered Beets	Celery	Rice Pudding
2.	Lima Bean Soup	Country Sausage	Mashed Potatoes	Baked Squash, Buttered Carrots		Gingerbread, Whipped Cream
3.	Broth With Rice	Fried Chicken	Mashed Potatoes	Buttered Peas	Celery and Olives	Ice Cream
4.	Cream of Spinach Soup	Spareribs	Escalloped Potatoes	Buttered Corn	Cinnamon Apples	Sliced Peaches
5.	Noodle Soup	Baked Liver	Candied Sweet Potatoes	Buttered Peas		Fruit Gelatin With Cream
6.	Creole Soup	Breaded Veal	Baked Potatoes	Buttered Green Beans	Coleslaw	Ambrosia
7.	Cream of Celery Soup	Escalloped Oysters	Parsley Potatoes	Baked Squash	Sliced Tomato	Jelly Roll
8.	Cream of Pea Soup	T-bone Steak With Gravy	Mashed Potatoes	Buttered Beets	Creamed Onions	Apricot Cobbler
9.	Broth With Alphabets	Meat Balls, Tomato Sauce	Mashed Potatoes	Fried Eggplant		Chocolate Pudding
10.	Cream of Corn Soup	Fried Chicken With Gravy	Mashed Potatoes	Buttered Asparagus	Celery and Olives	Ice Cream
11.	Cream of Mushroom Soup	Stuffed Beef Heart	Double Baked Potatoes	Escalloped Spinach	Coleslaw	Mixed Fruit
12.	Tomato Bouillon	Veal Stew	Mashed Potatoes	Buttered Peas		Cottage Pudding With Sauce
13.	Cream of Carrot Soup	Pork Chops	Escalloped Potatoes	Baked Squash	Cranberry Relish	Baked Pears
14.	Cream of Potato Soup	Red Snapper Steaks	Parsley Potatoes	Green Beans	Tartare Sauce	Fruit Gelatin With Whipped Cream
15.	Consommé and Vermicelli Soup	Veal Loaf, Catsup	Mashed Potatoes	Buttered Beets		Floating Island
16.	Mongole Soup	Roast Beef	Roast Brown Potatoes	Buttered Carrots		Apple Roll
17.	Bouillon With Barley	Roast Chicken	Mashed Potatoes	Buttered Broccoli	Celery	Ice Cream
18.	Duchess Soup	Chop Suey	Boiled Rice	Buttered Peas		Bread Pudding With Sauce
19.	Okra Creole Soup	Porcupine Balls	Mashed Potatoes	Creamed Cauliflower		Baked Apple
20.	Cream of Tomato Soup	Baked Hash	Creamed Potatoes	Baked Squash		Gingerbread With Whipped Cream
21.	Cream of Carrot Soup	Salmon Loaf, Catsup	Parsley Potatoes	Buttered Asparagus		Baked Pears
22.	Broth With Egg	Sliced Ham	Buttered Rice	Buttered Carrots		Fruit Whip
23.	Broth With Macaroni	Spareribs	Escalloped Potatoes	Green Beans	Pickle Relish	Applesauce
24.	Minestrone Soup	Roast Leg of Lamb	Mashed Potatoes	Escalloped Eggplant	Mint Jelly	Ice Cream
25.	Cream of Corn Soup	Steak With Gravy	Potatoes au Gratin	Stewed Tomatoes		Floating Island
26.	Yellow Split Pea Soup	Breaded Veal	Creamed Potatoes	Baked Squash		Baked Apple
27.	Tomato Bouillon	Roast Turkey, Oyster Dressing	Mashed Potatoes	Buttered Peas	Cranberry Relish	Ice Cream
28.	Cream of Pea Soup	Baked White Fish	Buttered Potatoes	Stewed Tomatoes	Tartare Sauce	Butterscotch Pudding
29.	Broth With Noodles	Country Sausage	Creamed Potatoes	Frosted Spinach		Cherry Cobbler
30.	Vegetable Soup	Veal Stew	Double Baked Potatoes	Peas and Carrots		Pineapple Delight

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.



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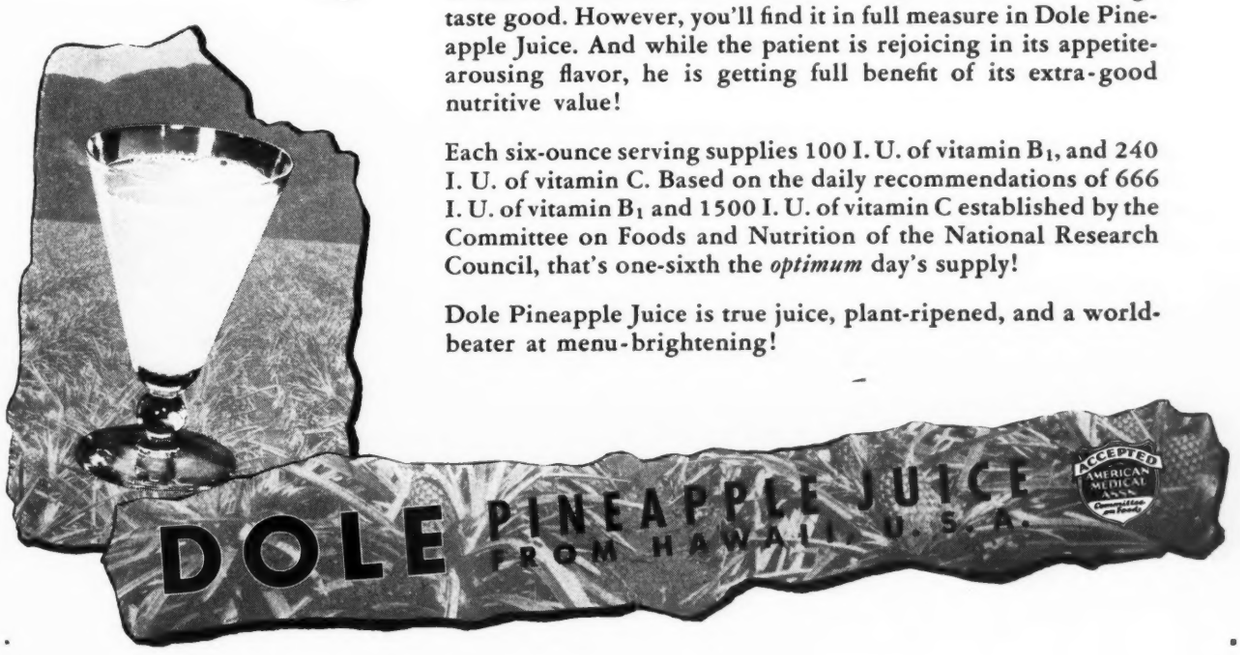


What I Expect of My Housekeeper

ALBERT H. SCHEIDT
Administrator, Miami Valley Hospital, Dayton, Ohio

THE housekeeper, now acquiring a degree of professional status in the hospital field, has a most thankless task and at the same time performs one of the most important functions in the hospital.

Unfortunately, many hospital administrators labor under the misconception that the directorship of housekeeping is a good "lame duck" position for some unfortunate woman in the community who has lost her money and needs to be put on a pay roll graciously and without loss of prestige; at the same time they feel that she rarely brings to the position a basic knowledge that fits her for the position.

I should expect a housekeeper to be well trained, first of all, because she has the third largest staff of personnel of any department in the hospital.

Second, I should expect my housekeeper to be well trained because of the large potential savings that can be effected in housekeeping supplies by a person who knows something about them.

Third, I should expect my housekeeper to be well trained because she, more than any other individual, can add to or subtract from the years of life of the equipment and physical plant and thus, through conservation, effect a savings many times her own salary.

The housekeeper not only supervises the third largest number of employes in the hospital organization but, likewise, she has to deal with a difficult group, not well educated and not overly paid. The housekeeping employes must be adjusted, sometimes with a great deal of difficulty, to the hospital routine; their work reeks with monotony. The leadership in personnel, which must be an inherent characteristic of the housekeeper, must be of a type that, in the face of all of these negative features, still encourages enthusiasm, interest, devotion and application.

In no field of human endeavor has there been so much ado about nothing as in the field of housekeeping supplies. Certain companies, with the interest of the hospital at heart, produce good products, sell them at reasonable rates and are in every way first line companies.

On the other hand, a greater number use the field of janitorial supplies as a means of exploiting the hospital field, the educational field, the governmental field and the business field. The only "out" is for a qualified housekeeper to be able to differentiate between the articles offered.

Of his department head who supervises the third largest number of employes in the hospital, Mr. Scheidt demands leadership, tact, business ability and an intellectual background that qualifies her to understand everything within the scope of household equipment and housekeeping personnel

Five years ago I started a study of floor waxes in order to arrive at the best possible solution to our floor problem. Three thousand floor waxes were listed by trade names before the study was completed and, rather than feeling that such a large figure was an exception to the variety offered on that particular phase of housekeeping supplies, I am inclined to think that dishwashing compounds, soaps and detergents, if similarly analyzed, would produce probably an equal or larger number of brands.

I should like to feel that a good housekeeper knew enough about the chemistry of soaps, detergents and waxes to be able to buy on specifications and to test the product received.

Having done so, I should like to think of that housekeeper holding to the established standard in future purchases, thereby guaranteeing a single quality of standard for the institution.

I should expect a good housekeeper to recognize the quantity of wax in liquid wax rather than the price per gallon and to understand many similar factors that go to make up intelligent specifications, economical usage and standardization of supplies, leading toward the elimination of waste.

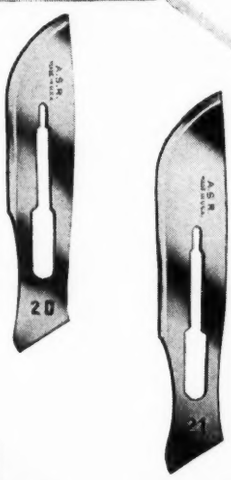
Assuming that we expect our housekeeper to be qualified and educated for the administration of a department that spends 10 or 15 cents out of each hospital dollar, we still may not have our housekeeping needs adequately met. Successful internal administration of the housekeeping department is a necessary requirement of a good housekeeper and is essential to tenure in that position, but this comprises only half the story.

A good housekeeper must have a good personality, character and disposition, making it a pleasure for other departments to cooperate with her. She must have executive ability to make apparent the results of her work and at the same time she must keep the existence of the department as inconspicuous as possible.

Housekeeping in the hospital is not an entity in itself. It is a basic responsibility to carry out a cleaning and supply function for all of the departments within the institution.

Paper presented at the Tri-State Hospital Assembly, Chicago, May 1941.

"Here's One Worry the Doctor Never has!"



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It is not a difficult problem to sit down and analyze the housekeeping problems of the hospital and then to complete a schedule that will cover these points regardless of the deterring effects on other departments. However, it requires real executive ability to develop a flexible schedule that gets the housekeeping done in face of delays occasioned by doctors' visits with patients, nursing procedures being carried out, food being served to patients, visitors calling on patients and, finally, the rest periods of the patients during which time they are not to be disturbed unnecessarily by housekeeping employes.

I suppose we should add to the duties of the good housekeeper the fact that she not only must be properly trained but also must exercise the greatest amount of ingenuity, skill and diplomacy in carrying out the function of her department so as to accomplish the maximum of good cleaning with the least amount of friction.

Another desirable characteristic is the willingness to inspect the work of the individuals in her department. In all too many instances the housekeepers in hospitals have become glorified clerks or "employe chasers" throughout the buildings. Standardization has been carried beyond the point at which it is practicable; in fact, in many instances, it has been carried to a point at which it has become an added expense.

As I write this, I am walking over a floor that has on it an excess amount of wax; this is due to the fact that some low salaried person has an assignment card on which is stated, "Every —— days, wax the floor in Mr. Scheidt's office." Aside from the danger to life and limb that exists as a result of an overwaxed floor, I see a loss in labor and in supplies because of overstandardization rather than an attempt to adjust the waxing to the amount worn off by my sporadic pacing.

The good housekeeper, either through her own observation or through training of subordinates, should be able to avoid such practices. To say that standardization in such instances costs less than the possible damage done by nonattention is just about as erroneous as to say that the tires on an automobile should be blown up every day. Wall washing is another such housekeeping procedure that, unfortunately, has fallen into a program of standardization, with resulting damage to the paint. Last, but not least, is the routine mopping at 7, 11 and 4, whether the corridor needs it or not.

A good housekeeper can easily save 20 per cent of her operating budget by close coordination of the housekeeping work done with the housekeeping work that needs to be done. I believe the reason that more housekeepers are not able to effect this saving is due to the fact that many administrators have failed to recognize the importance of her department. While in the department of nursing there exists a director, one or more assistants, a number of supervisors and a quantity of head nurses, with a view to adjusting the nursing service to the needs of the patient, in housekeeping departments the person next in importance to the housekeeper in charge is, in all too many instances, a low salaried employe.

Entirely aside from the cleaning function, a good housekeeper can be expected to have a thorough knowledge of linens, draperies, upholstery covers and the entire line of cloth and fabric goods, including leather. The housekeeper can be of inestimable value to the purchasing agent in discerning quality. I should expect a housekeeper to know the respective wearing qualities of fabrics, to know the difference between long-time investment in good materials and short-time investment in cheap materials.

A good housekeeper should not only be able to develop a color scheme for a particular room but should also be able by effective use of color and by proper selection of floor coverings, wall tints and draperies to make each room distinguished, using, at the same time, 80 per cent uniform equipment and supplies in carrying out the decorating program of the entire institution.

A good housekeeper will be able to make use of practically any piece of equipment in any room.

Finally, a good housekeeper must be an individual whose primary interest is in the patient. Every thought, every move and every act must be directed around that one central theme.

For Better Wall Washing

HERE is a suggestion or two on methods of wall washing based on the experience of W. A. Davenport, superintendent of buildings and grounds, Michigan State College, East Lansing, Mich.

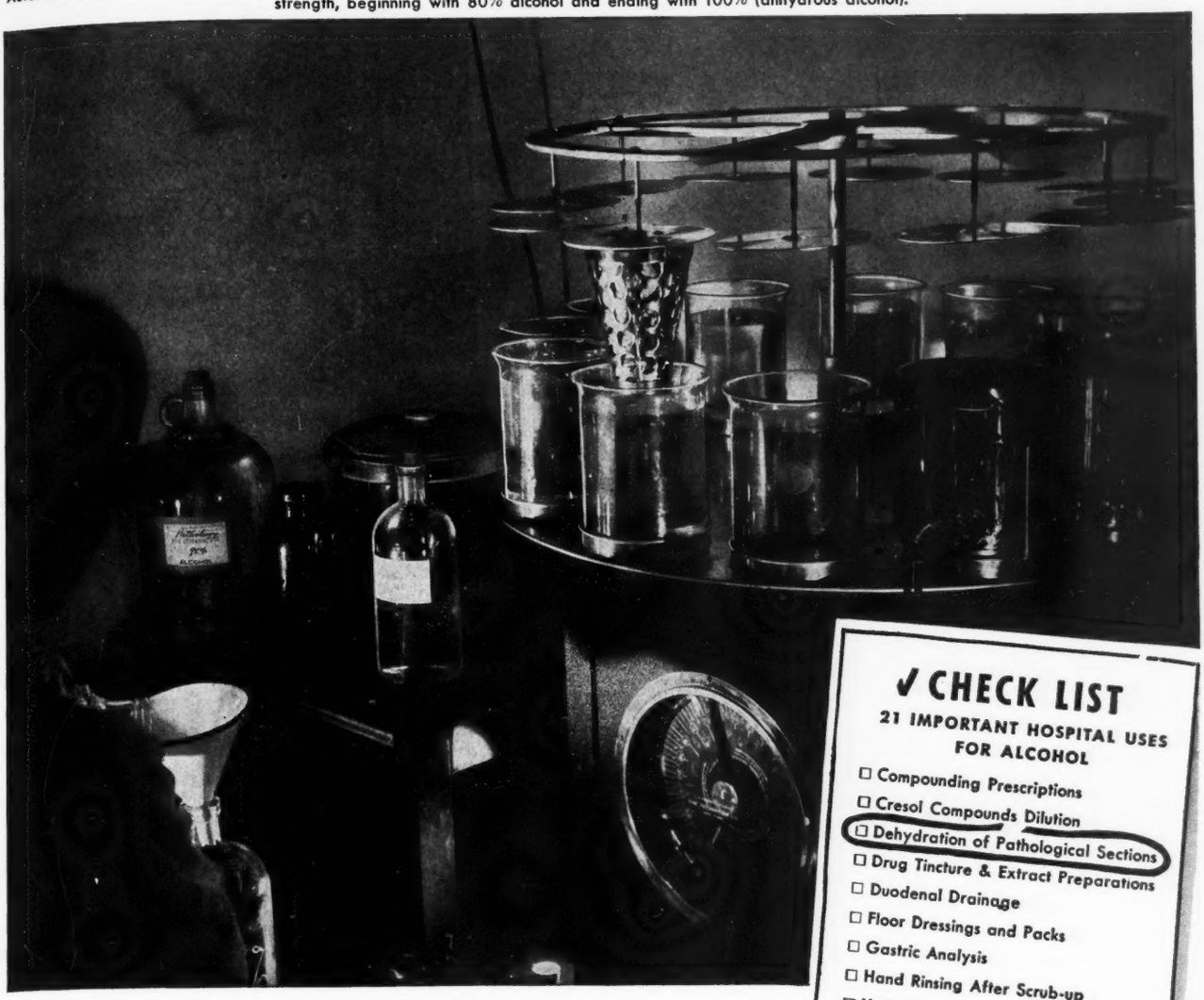
"The most satisfactory equipment consists of two pails," he states, "one for the cleaning solution and another for the rinse water, together with clean sponges and ladders or scaffolding. The cleaning compound should be such that it will cut the dirt without injuring the surface.

"Procedure in wall washing varies. Some begin at the bottom and wash up the wall; others begin at the top and work down. Either method is satisfactory if properly done. In mixing the cleaning solution, regardless of the chemical used, start with a weaker solution and add cleaner until a mixture is obtained that will remove the dirt satisfactorily without injuring the paint. One pail should contain clean rinse water. Many hours of work may be spoiled by using dirty rinse water.

"The washing area depends on the type of wall and the kind of paint on the wall. When flat paint has been used the area should be kept small, between 2 and 3 square feet, because the solution should not be allowed to dry at any time during the operation. A full gloss painted area should not exceed 4 or 5 feet square or an area within easy reach without moving the body too far. The whole area should be rinsed immediately after being cleaned and should not be allowed to dry until well rinsed. As mentioned above, particular care should be exerted in keeping the rinse water clean.

"Any particularly bad marks on the walls may be removed later by spotting with a little stronger solution. This eliminates the danger of making the solution so strong in attempting to remove the mark that the rest of the paint is injured."

Automatic machine dehydrates pathological specimens by immersing them successively in each of nine jars containing alcohol of progressively increasing strength, beginning with 80% alcohol and ending with 100% (anhydrous alcohol).



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USI PURE ALCOHOL

Service Plus Teaching

B. T. HOWILER

Chief Pharmacist, University Hospital
University of California, San Francisco

THE hospital pharmacy plan at the University of California Hospital, which has been in operation only three years, has proved definitely its twofold value, economic and educational, to the hospital and to the university. Through the enlargement of the scope of its activities savings have resulted in the medications supplied both to patients and to the hospital itself. The demand for trained personnel in hospital pharmacy indicates that their value is becoming day by day more apparent.

The present plan is the outgrowth of the ground work laid in 1936 by members of the faculties of the colleges of medicine, pharmacy and dentistry of the University of California. At that time a pharmacy committee was appointed by the president of the university, consisting of the dean of the college of medicine, dean of the college of pharmacy, dean of the college of dentistry, the hospital superintendent, the chiefs of the divisions of medicine, surgery, pediatrics, obstetrics and gynecology and the chief pharmacist of the hospital.

This committee was established to "promote coordination and cooperation among the schools of medicine, dentistry and pharmacy in regard to the hospital pharmacy and the hospital and clinic dispensing, so that more efficient use may be made of facilities available at the medical center for teaching and training in dispensing and so that more efficient dispensing services may be rendered."

The function of this committee is advisory; it is responsible for the following activities.

1. To formulate the drug policy of the medical center, which includes the hospital and the out-patient clinics.

2. In conjunction with the college of pharmacy, to establish and maintain a laboratory for the manufacture of pharmaceutical preparations. The administration of this division is under the direction of the college of pharmacy.

3. To supply and control ward service drugs.

4. To set up and print a hospital pharmacy formulary.

By setting up the organization in this manner, the hospital superintendent had complete control over the actual administration of the hospital pharmacy while the pharmacy committee acted in an advisory capacity to him in the establishment of policies for the hospital pharmacy. Problems pertaining to pharmacy thus were placed in the hands of the members of the professions using the services of the pharmacy most.

At the time the pharmacy committee was established, it was decided to enlarge the scope of training in pharmacy by offering internships in hospital pharmacy. This plan had been in operation with great success for a number of years at the University Hospital in Ann Arbor, Mich., and at Lakeside Hospital at Western Reserve University in Cleveland. In 1938 the first applicants were accepted for intern training in hospital pharmacy at the University of California Hospital; since its inception 10 men have been given advanced training in hospital pharmacy.

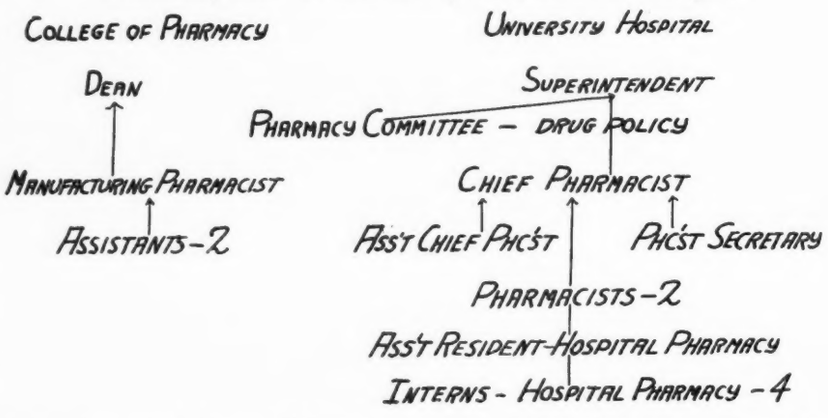
The present personnel of the hospital pharmacy is built around five permanently employed pharmacists augmented by five hospital pharmacy interns.

The permanent staff consists of the chief pharmacist, assistant chief pharmacist, pharmacist secretary and two registered pharmacists. The rotating staff is composed of an assistant resident in hospital pharmacy together with a somewhat fluctuating number of interns in hospital pharmacy. The permanent personnel is sufficient to permit normal operation of the pharmacy and, at the same time, a certain amount of didactic training of interns.

The personnel of the manufacturing laboratory is built around a permanently employed pharmacist who serves in the double capacity of director of the laboratory and instructor in the college of pharmacy. This pharmacist supervises two part-time assistants and from eight to 15 students, depending upon the size of the classes in manufacturing pharmacy.

The requirements placed on the pharmacy service in a teaching hospital are similar to those in a non-teaching hospital. The only difference lies in the magnitude of these requirements. We are faced with the task of furnishing a pharmacy

Pharmacy Plan at University of California—Fig. 1



Pharmacy Plan at University of California—Fig. 2

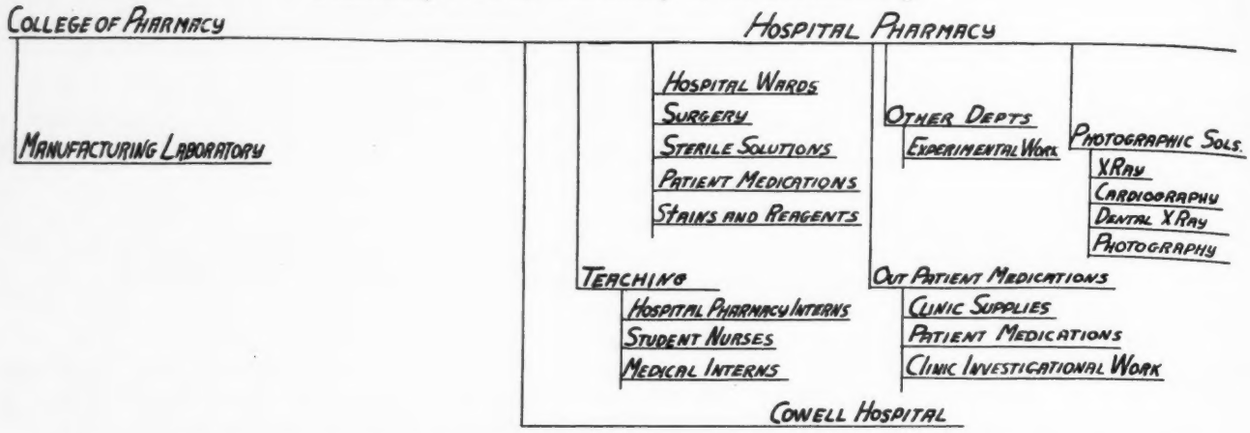


Chart showing how pharmacy services at the University of California are dispensed among the various departments of the University Hospital. Heaviest demands on the pharmacy, it is reported, come from wards and the surgical department.

service in an institution of 350 beds the operation of which is built around the care of acutely ill patients. For this reason, great depth in demand is placed on the pharmacy service.

Our pharmacy services reach into many of the operating departments of the hospital. The wards are particularly active and a great deal of our operating time is spent in supplying their demands and seeing that their stocks are kept at an optimum working level, as well as in taking care of individual patient orders. In a like manner, great demands are placed on our service by surgery and its affiliates, delivery rooms and experimental surgery.

The supplying of all photographic solutions used on the medical center campus accounts for a great deal of time and effort.

Cowell Hospital on the Berkeley campus of the university comes in for its share of manufactured supplies, used in the care of some 15,000 students on that campus.

Our clinical out-patient department with an annual yearly total of some 160,000 visits accounts for a large part of our operating load; in this operation alone we are called upon to fill from 65,000 to 70,000 individual prescriptions per year.

We are now developing plans for supplying stains and reagents not only to the central laboratories and ward laboratories of the hospital itself but also to the various teaching and research laboratories wherein such stains are used.

Full responsibility for each of the various phases of pharmacy operation is placed upon one or more members of the permanent personnel. One man may be fully responsible for all in-patient medications, this to include the control of ward stocks and ward narcotics, inspection of those stocks and their replacement and inventory. Thus, one man is given the full responsibility of answering complaints on shortage of stocks and any other matter pertinent to ward or in-patient medication. He, in turn, is responsible to the chief pharmacist for the correlation of his responsibilities with those of the rest of the organization. Through decentralization of authority in this manner, we are able to maintain a much more smoothly operating organization.

In a like manner, the assistant chief pharmacist is fully responsible for all out-patient medications, their preparation, packaging and dispensing.

The pharmacist secretary accepts full responsibility for all telephone orders, questions, inquiries and the host of other requests that come in by telephone. Those questions concerning materials or substances with which she is not familiar are turned over to another member of the permanent personnel for attention. By having our permanent personnel make distinct efforts to answer such inquiries, we are teaching our interns the value to the service and to themselves in answering questions intelligently.

The remaining permanent pharmacists are also given definite procedures to control, such as hospital manufacturing and stock control.

With the routine of the service divided in such a manner, the chief pharmacist must serve as a coordinator of all these services. This is done through the medium of monthly staff meetings at which time problems are discussed and responsibilities shifted and divided if they become too heavy.

To correlate the teaching aspects of the intern system with the plan of operation is a second phase of our pharmacy plan. For this reason, every effort is made at the time of permanent staff selection to obtain men who have an exceptional educational background as well as practical experience. As part of our teaching program, in addition to weekly seminars and assigned work, definite advantage is taken of the manufacturing laboratory and the application of its operation in the day-to-day operation of the pharmacy. It is not our intent to attempt to teach each intern that he should necessarily contemplate manufacturing on the same scale as is practiced here if he is placed in a hospital, but we do feel that the fundamental training that goes with such experience will be invaluable to him in any hospital pharmacy with which he may become affiliated.

We place before each intern who passes through our training period the information gleaned through the combined years of training of our permanent staff, together with the opportunity to learn to evaluate much of the material presented to the medical profession. This training is in addition to that of the routine operation of the hospital pharmacy and its proper correlation with the other working departments of the hospital.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.

Psychologic Usefulness of Benzedrine Sulfate

It has been nearly four years since benzedrine sulfate was accepted by the council of pharmacy and chemistry of the American Medical Association. Since that time further clinical reports and experimental studies have been published pointing out the newer pharmacologically justified fields of usefulness for this drug and extending its valuation over greater numbers of patients. The total accumulation of evidence and experience has recently been adequately summarized by Myerson.

Pharmacologic Properties

The pharmacologic properties of benzedrine sulfate are of two distinct and unrelated types: the sympathomimetic and the wakeful-psychologic. The sympathomimetic effects require higher dosage than do the wakeful-psychologic effects.

The former effects are well known and have been well defined as the result of ten years of experimental work. It is in the latter field that the most modification of therapeutic application has lately been accomplished.

The sympathomimetic properties follow the general plan of all such substances in that benzedrine causes arteriolar constriction and visceral smooth muscle relaxation. To produce these results, doses of from 20 to 30 mgm. by mouth are required. In the eye, concentrations of from 0.5 to 2.0 per cent dilate the pupil, widen the palpebral fissure and increase intra-ocular tension.

The wakeful psychologic effects, as mentioned, bear little relationship to the sympathomimetic effects. They appear following doses of from 1 to 10 mgm. The initial sensation is one of pleasant wakefulness with a feeling of increased vigor and of increased physical and mental power. When dosage is increased until the unpleasant stage is reached, the sensation becomes one of being too alive, too responsive to environmental influences and of awareness of approaching unpleasant excitement.

Therapeutic Applications

The adaptation of these principles covers several fields of application. The earliest use made of these psychologic aspects was by Ulrich and by Printzmetal and Bloomberg. The former noted that sleeplessness was caused by the use of a benzedrine inhaler and applied his discovery to the treatment of narcolepsy. Here, the administration of from 30 to 50 mgm. per day in divided doses, of which the bulk is given in the morning to promote diurnal wakefulness, is successful in ameliorating the symptoms of pathologic drowsiness. Bloomberg has recently reported cases maintained on such dosages for a period of three years without loss of potency of drug activity and without increase in mean blood pressure.

The exploitation of this wakefulness-promoting property of benzedrine for extension of physiologic wakefulness by persons driving long distances, by students preparing for examinations and by doctors who self-medicate themselves constitutes an abuse of a valuable drug. Since benzedrine does not have the property of altering metabolism, these people are running on borrowed physical energy for which the governor, fatigue, is blocked off by the drug. Eventually, they have to repay that physical debt which, if not repaid, can result in illness through lowered resistance. There are a few instances in which to fall asleep would be disastrous and in these cases use of benzedrine is justified. On those occasions from 5 to 10 mgm. of benzedrine sulfate is effective.

A field of application of a more specific type is in the treatment of barbiturate poisoning. Here fairly heavy doses can be given subcutaneously or intravenously. If given by the latter route, 30 mgm. had best be dissolved in 10 cc. of distilled water and injected over a period of ten minutes. If given in therapeutic amounts, barbiturates can be combined with benzedrine sulfate to obtain the sedative effect of the barbiturate unhampered by the "hangover" and the depression that these drugs produce. From 5 to 10 grains of benzedrine sulfate combined with 3 grains of amytal or with 1 grain of phenobarbital are good proportions to use. The two are mutually antagonistic, each canceling the disagreeable properties of the other. This is especially valuable in the treatment of epilepsy in the treatment of which phenobarbital is often given over long periods, producing lassitude and weariness. Benzedrine does not increase the incidence of epileptic attacks under these conditions.

Rieffenstein and Davidoff have recently shown that benzedrine sulfate is a physiologic antagonist of the sedative alcohol. In a series of acute and chronic alcoholics, they found it particularly useful in the acute type. In this condition it acted as a morning "lift-up," reducing the desire for more alcohol. Here it is not a specific cure for the disease but merely an adjunct to proper psychologic and sociologic readjustment.

In the neuroses, the use of benzedrine sulfate is a matter for clinical trial in each case. If it makes the patient jittery, it should be withdrawn. It is of most use in transitory neurotic states, especially of the reactive types. For these persons it is an aid in meeting difficult situations. Here is one instance in which benzedrine and the barbiturates can well be combined.

The function of benzedrine in the treatment of obesity is twofold. First, the relaxation of the gastro-intestinal tract tends toward reduction of appetite. Second, the psychic properties tend to increase physical activity with a consequent increase in metabolism. Here, again, its use is adjunctive to a carefully controlled diet.

Parkinson's disease produces, among others, symptoms that resemble narcoleptic attacks. For this reason benzedrine is a useful complement to stramonium or belladonna therapy. Benzedrine is synergistic in its action with these two drugs.

Contraindications

Contraindications to the use of benzedrine include hypertension and cardiac disease because of its pressor effect, sleeplessness because of its aggravation of this condition and atonic conditions of the gastro-intestinal tract and of the genito-urinary tract because of its sympathomimetic tendency to increase the lack of tone.

Idiosyncrasy to this agent occurs as in so many other valuable remedies. The symptoms produced are both psychic and sympathetic: a sensation of fullness in the head, severe headache, giddiness, excitement, irritability, dryness of the mouth and a queer feeling in the "stomach."—Harold F. Chase, M.D.

Painted Labels

Peking Union Medical College, Peiping, China, always kept all routine ward drugs, approximately 150 in number, in bottles and jars with hand-painted labels. The advantages of painted labels, they found were: they made for uniformity throughout the hospital; the labels were easily read at a distance; there was no danger of the label falling off; bottles could be washed repeatedly without affecting the label; labels could not be changed on the ward; they did not require renewing. J. Cameron, the chief pharmacist, reported not long ago that the hospital had some bottles with painted labels that had been in constant use ten years.

News in Review

Census Bureau Report Shows Need for 2000 More Hospitals Averaging 170 Beds

RUTH HILL ZIMMERMAN
Washington Correspondent, The MODERN HOSPITAL

WASHINGTON, D. C.—Statistics concerning bed facilities available for medical care of the people of the United States in 1939, just released by the census bureau, show that 1,282,785 beds were available in 9614 institutions, including hospitals and sanatoriums, nursing, convalescent and rest homes and other institutions with infirmaries.

Most of these beds—1,186,262—were in the 6991 hospitals and sanatoriums covered in the report of these institutions; 5703, or 81.6 per cent, were registered with the American Medical Association and provided 1,155,428 beds.

The 1288 institutions not registered are not defined by the census bureau. However, they contained only 2.6 per cent of the bed accommodations and provided only 1.7 per cent of the total reported days of care.

Hospital facilities for the country, according to a census bureau press release which announced the report, were below the "minimum requirements for adequate medical service" set up in 1933 by the Committee on the Costs of Medical Care. The number of hospital beds in registered and nonregistered hospitals combined totaled 90 per 10,000 population as contrasted with a minimum of 116 needed for "adequate medical service" to meet this minimum.

The census bureau stated that 2000 more hospitals containing an average of 170 beds would have to be built.

The rate varies greatly among the states. It ranged from a high of 193.9 in the District of Columbia and 153.4 in Massachusetts to a low of 44.4 in Mississippi.

New York, Colorado and Maryland also had more than 124 beds per 10,000 population in 1939.

Hospital Library Standards Recommended by Study

In a recently published study, the University of Minnesota recommends the following standards for hospital libraries:

For a 100 bed hospital, 500 books, 5 magazine subscriptions, librarian, eight hours a week, $450 expended per year; for a 250 bed hospital, 1000 books, 10 to 12 magazine subscriptions, librarian, twenty hours a week, $1000 expended per year; for a 500 bed hospital, 2000 books, 25 magazine subscriptions, one full-time librarian, $2000 expended per year; for a 750 bed hospital, 2500 books, 35 magazine subscriptions, one full-time and one assistant librarian, $3425 expended per year.

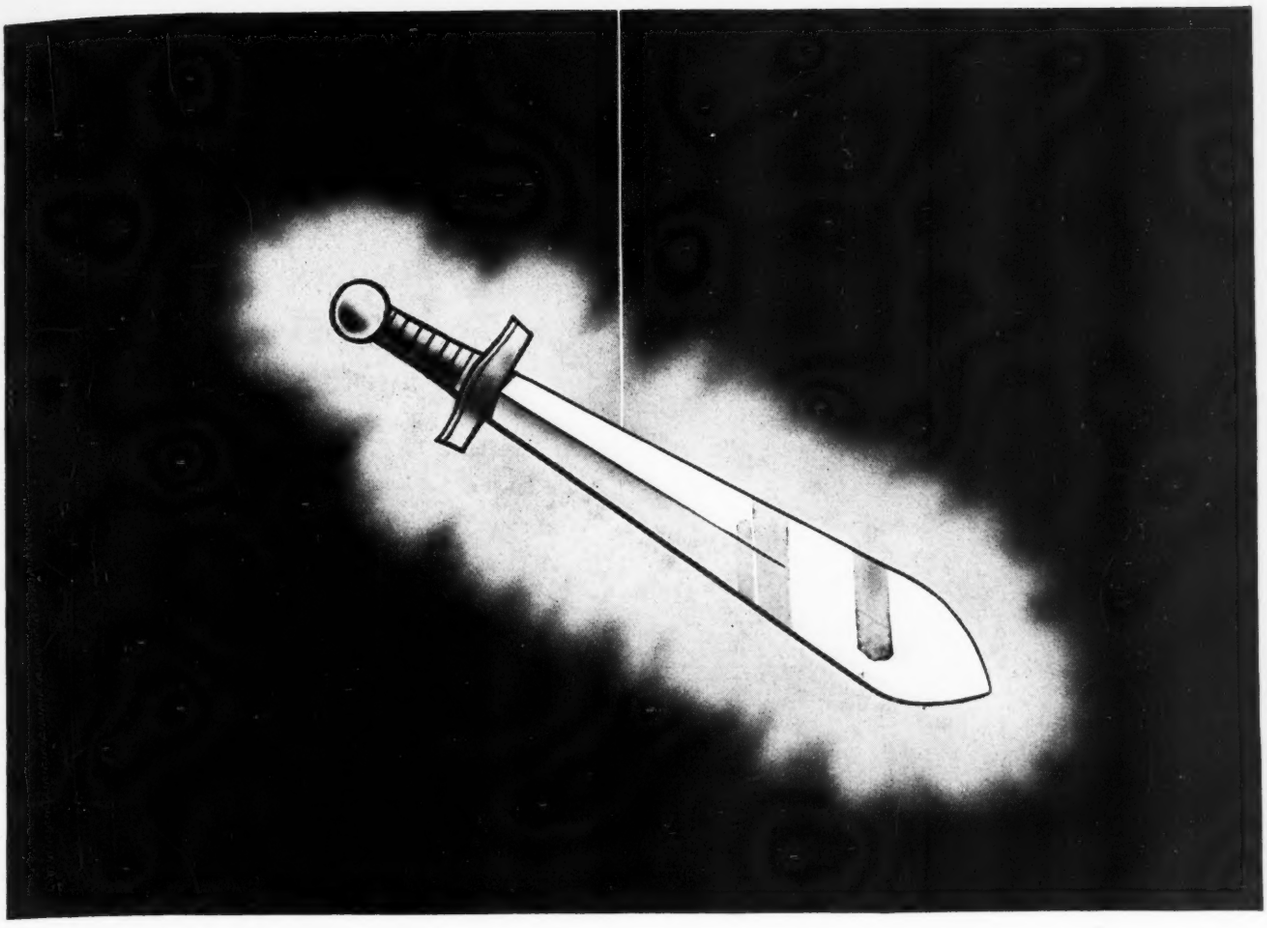
Hospitals Included in A-10 Preference Rating for Emergency Repairs

Hospitals, clinics and sanatoriums were included among the 20 essential industries for which an emergency repair preference rating of A-10 was established by Donald M. Nelson, new director of priorities, on September 9. The new plan, already in operation, provides a means of obtaining parts needed to repair actual or imminent breakdown of equipment and may also be used to get deliveries for "emergency inventory." It takes the place of a more elaborate order, covering maintenance and repair work, which was announced on August 8 but was not actually issued because of administrative difficulties in handling the paper work involved, according to the division of priorities. Industrial and academic research laboratories are also included in the new order.

Hospitals, like other industries and services listed in the order, may apply the preference rating to a delivery of material by endorsing the following statement on the original and all copies of the purchase order or contract for material: "Purchase order for repair or emergency inventory—Preference Rating A-10 under Preference Rating Order P-22."

Suppliers of the industries included in the order may obtain a similar preference rating by endorsing a similar statement, as follows: "Purchase order for material required to fill a duly rated order for repair or emergency inventory. This purchase order bears Preference Rating A-10, Preference Rating Order P-22."

This preference rating order is regarded as an interim measure and will expire, unless it is revoked sooner, on February 28, 1942. Special orders, covering the particular problems in certain industries, may be worked out and other industries may be added to the order. It was indicated to The MODERN HOSPITAL representative by the Office of Production Management that special provisions for hospitals were already under discussion.



THE SWORD THAT HUNG BY A HAIR . . .

Remember Damocles' Sword? How Over His Head It Hung By a Hair?

Seemingly minor things are often of great importance. The judgment of your hospital *may* depend upon the quality of your ware. Knowing this, many leading hospitals from coast to coast use only Vollrath Enameled or Stainless Steel Ware . . . Since 1874 — sixty-seven years ago—Vollrath has steadfastly maintained its well-deserved leadership. Today, as always, Vollrath Hospital Ware is *designed* for beauty and utility and is *built* for long life . . . We urge you to investigate now!

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Five Hospital Projects Approved Under Defense Public Works Program

To relieve overcrowded conditions in defense areas, President Roosevelt has approved grants to five hospital projects under the Defense Public Works program which was set up by the Community Facilities (Lanham) Act.

The five projects approved as this issue goes to press are:

An addition to the Norfolk County Hospital, Norfolk, Va., including 66 additional beds to serve Negro patients. A nurses' home, laundry, boiler house and alterations to the existing building are included. The estimated cost is $333,364.

A new 124 bed general hospital for Negroes to cost $348,300 at Newport News, Va., to be sponsored by the city of Newport News.

A hospital addition and nurses' home at Ravenna, Ohio, to cost $250,000. The nearest hospital is at Akron, 18 miles away. This project is sponsored by the county commissioners of Portage County.

Alterations and a 28 bed addition to Silver Cross Hospital, Joliet, Ill., to cost $80,000. This will bring the hospital's capacity to 148 beds and 30 bassinets.

A $350,000 addition to Queens Hospital, Honolulu, T. H., to aid in caring for defense personnel stationed on the island.

Each of the applicants for a D.P.W. grant has indicated that it will be able to operate and maintain the project after construction is completed without further assistance from federal funds.

700,000 General Motors Employes and Dependents Enroll in Blue Cross Plans

With the announcement on September 23 by John Mannix, director of Michigan Hospital Service, that General Motors employes from coast to coast are to be given the opportunity to enroll in Blue Cross plans approved by the American Hospital Association, a new milestone has been reached.

General Motors Corporation decided to cooperate with its employes to make the full family service of Blue Cross plans available on a pay roll deduction basis wherever company plants are located.

General Motors employes have had a hospital and surgical benefit plan since July 1939. However, it did not provide protection for the family dependents and it was felt that Blue Cross plan service contracts would be better.

Upward of 275,000 employes and 425,000 of their dependents are affected by the decision, which will make the services of 22 of the 67 approved plans available.

Directors of these 22 Blue Cross plans met in Detroit on September 19 to discuss enrollment procedures with executives of the corporation, including B. D. Kunkle, vice president in charge of industrial relations; A. C. Anderson, comptroller, and Ralph Long, director of the insurance department.

Negotiations for this enrollment were conducted over a period of several months through Michigan Hospital Service. The corporation has indicated a desire to cooperate to the fullest extent in facilitating enrollment in all plans throughout the country that are in a position to serve their employes.

In Michigan, surgical service in addition to hospital care protection will be made available to employes through cooperation with Michigan Medical Service. In areas in which surgical benefits are not available, employes will be permitted to enroll in the Blue Cross plan for hospital care protection for themselves and their families and may continue surgical care insurance under the present General Motors arrangement, if they so desire.

October 28 Designated as "Blue Cross Day" by A.H.A.

October 28 has been designated as "Blue Cross Day" by the public education committee of the hospital service plan commission of the American Hospital Association. On that date 2,000,000 Blue Cross subscribers will have been admitted to hospitals for hospital service, 250,000 babies will have been born under Blue Cross protection and $100,000,000 will have been paid to member hospitals for services to subscribers.

National releases and announcements will emphasize the hospital service plan movement as a whole and material for local newspaper stories, speeches and exhibits will be made available to participating plans.

The public education committee of the commission announced last month the preparation of four radio scripts prepared on one record for the use of hospitals or hospital service plans.

Three of these public relations' scripts, each for a five minute program, are on one side of the record. They deal with "Roentgen and the X-Ray," "A Dutch Janitor (Van Lleeuwenhoek)," and "Pasteur's Experiment." On the other side of the record is a fifteen minute program on cancer entitled "Unconquered Enemy."

McNutt Is Named Director of Defense Health Office

A new Office of Defense Health and Welfare Services has recently been set up within the Office for Emergency Management and Paul V. McNutt, federal security administrator, has been appointed director. Previously, Mr. McNutt was coordinator of such activities. President Roosevelt specified in the executive order establishing the new office that it should work closely with the Office of Civilian Defense in its relationships with state and local groups. The effect of the order is to extend Mr. McNutt's authority and to clarify the relationship of this office with other defense agencies.

The Health and Medical Committee, of which Dr. Irvin Abell is chairman and Dr. James A. Crabtree is executive secretary, has now become an advisory group for the new Office of Defense Health and Welfare Services instead of for the Federal Security Agency.

State Legislatures Pass Hospital Licensing Laws

A hospital licensing law designed to prohibit unqualified institutions from calling themselves hospitals has been passed by the Minnesota legislature and will become effective on January 1. The bill was sponsored by the Minnesota Hospital Association.

Pennsylvania H.B. No. 1270, providing for licensing of hospitals operated only for profit, was approved by the governor during the regular 1941 session of the legislature.

Medical Center Near Completion

The new $4,850,000 U. S. Naval Medical Center at Bethesda, Md., is expected to be turned over to the Navy Department late in October. About two months will be needed to equip the Naval Hospital and other buildings that comprise the center; it will probably be commissioned in January. The center will consist of the Naval Hospital, Naval Medical School, Naval Dispensary and Naval Dental School. It is situated on a 265 acre tract and includes a central group of communicating three and four story buildings surrounding a 20 story tower. Several separate buildings will house nurses, members of the hospital corps, officers, a laundry, garage and power and refrigeration plant.

President-Elect Pro Tem Named

Mrs. Margaret H. Rose, administrator, Wichita General Hospital, Wichita Falls, Texas, recently was elected president-elect pro tem of the Texas Hospital Association to serve in the absence of Dr. E. M. Dunstan. Doctor Dunstan was called for active Army service in the medical corps.

Minnesota Establishes Group Medical Care on Prepayment Basis

Under the insurance laws of the state of Minnesota, a plan for complete medical care on a prepayment basis has been made available to the members of Group Health Mutual of St. Paul.

The plan will provide insurance against the full cost of medical care for employed persons and partial coverage for dependents. Medical care will be made available through clinics as part of their established private practice.

Provision is made thereby for general medical care and, when desirable, for care by specialists in the various departments of medicine and surgery, and for such laboratory services and equipment as may be needed for complete health supervision. The clinics will charge their regular fees for service, which the company will pay the member.

Hospitalization is now provided under the hospital insurance plan. Complete medical care for the employed person will include care in the home, the office and the hospital, limited to $1000.

The premium for medical care of an employed person is $2 per month.

Nursing Schools Invited to Cooperate in National Program for Aid Training

WASHINGTON, D. C.—Some 800 nursing schools have just been invited by Mayor F. H. LaGuardia, director of civilian defense, to participate in the nation-wide program to augment nursing service of hospitals, clinics, public health and field nursing agencies. The invitation, issued by letter to hospital executives and directors of nursing schools, late in September, called upon these institutions to cooperate with the American Red Cross and the Office of Civilian Defense in training volunteer nurses' aids, with the goal of providing each registered nurse with one trained aid or more so that she may extend her services to many more persons.

"The deficiency in nursing personnel will be overwhelmingly accentuated if this country becomes actively involved in defensive combat," Mayor LaGuardia predicted in extending his invitation to the schools.

Five essential requirements for the effective use of volunteer nurses' aids were listed by the Office of Civilian Defense in urging cooperation of hospitals and nursing schools in training aids. First, they should be intensively trained. Second, throughout the period of the national emergency they should continue to give an adequate number of hours of service in a hospital, clinic or field service. Third, they should be prepared to conform to the discipline of the organization in which they are to work. Fourth, they are to render service without remuneration. Fifth, they are not to replace paid hospital personnel, but are to serve specifically as nurses' assistants.

The nursing schools to which the invitation was sent are affiliated with hospitals of 100 or more beds on the approved hospital list of the American College of Surgeons.

Dietetic Group Meets in St. Louis

The American Dietetic Association will meet for its twenty-fourth annual convention in the Hotel Jefferson, St. Louis, October 20 to 23. In line with current events, nutrition and national defense will be discussed by Dr. Russell M. Wilder, chairman of the committee on foods and nutrition, National Research Council. The association plans to conduct various workshops during the week of the convention at which members can discuss their particular problems.

New House Organ Published

"News Review" is the name of the new house organ published by Women and Children's Hospital, Chicago. It is a six page paper covering both professional and social aspects of the hospital.

CRITICAL MOMENT

Anesthesia accident! For just such critical moments it is advisable to have available at all times a supply of Suprarenalin Solution Armour. In conjunction with artificial respiration, it may be life saving.

Hemorrhage, shock, asthmatic spasm, asphyxia, nitritoid reaction are other critical conditions which may call for the prompt use of suprarenalin. But it is important to make certain that the preparation upon which you depend in these emergencies is potent, efficient, standardized and pure. Behind Suprarenalin (Epinephrin) ARMOUR are forty-five years of painstaking research in the manufacture of endocrine preparations. Only the most select of our tremendous supply of fresh animal glands are employed and every step in the processing is carefully supervised and checked to insure a product that meets the high and unvarying ARMOUR LABORATORIES standard.

Specify *ARMOUR* whenever ordering or prescribing medicinals of animal origin.

SUPRARENALIN ARMOUR

available in these forms:

SUPRARENALIN SOLUTION 1:1000
Supplied in 1 cc. ampoules and 1 oz. rubber-capped vials.

SUPRARENALIN CRYSTALS
Supplied in 1 grain vials.

SUPRARENALIN INHALANT 1:100
Supplied in ¼ oz. and 1 oz. bottles for oral inhalation.

SUPRARENALIN OINTMENT 1:1000
Supplied in collapsible tubes with applicators.

SUPRARENALIN SOLUTION 1:10,000
1 cc. ampoules for hypodermic or intravenous use.

THE *Armour* LABORATORIES

CHICAGO, ILLINOIS

Army Nurse Corps Revised Estimate Indicates Need for Increased Enrollment

WASHINGTON, D. C.—The Army Nurse Corps has recently revised upward its estimate of the number of nurses that it should enroll during the current year and now anticipates need for more than 10,400 additional nurses by July 1, 1942. Other federal government nursing services, whose estimates are included in a summary just made by the office of the surgeon-general of the Army, have indicated that they, too, will need many additional nurses within a short period.

The decision to retain selective service trainees for longer than a year means that the Army Nurse Corps must add approximately 4000 more reserve nurses to care for new trainees being inducted this year. The actual strength of the corps on August 27, 1941, was 5973 (1349 regular and 4624 reserve) as compared with a total authorized strength of 8237 (1875 regular and 6362 reserve). Thus, in order to meet the authorized quota there is a need for 2264 more nurses (526 as regulars and 1738 as reserves). The Army Nurse Corps anticipates that 40 per cent of reserve nurses accepting one year assignments will request discharge at the end of their twelve months' service. Therefore, 4144 reserve nurses over the authorized quota must be enrolled in order to take the places of retiring nurses.

The Navy Nurse Corps numbered 748 on September 15, with an authorized quota of 838 for the fiscal year ending June 30, 1942. The Navy has not made public estimates of any need it may have for additional nurses. The Veterans' Administration, which reported 4682 active nurses, wants 1000 more. The hospital nursing service of the U. S. Public Health Service estimates a need for 350 nurses in addition to the 937 reported in the service. The Office of Indian Affairs, which has 783 nurses on its staff, wishes 250 additional enrollees.

The American Red Cross First Reserve, reported as numbering 20,549, needs to enroll 20,000 additional nurses. This list is the official register from which the Army and Navy draw their nurses.

Six Story Pavilion Moved

By means of 52 hydraulic jacks, the six story contagious disease pavilion of Willard Parker Hospital, New York City, recently was moved 60 feet west of its former location to allow for the expansion of East River Drive. The pavilion will be opened for occupancy on its new site later in the fall.

A-2 Rating for Laboratory Equipment Granted by O.P.M.

Scientific research was put high in the nation's values last month when the division of priorities of the Office of Production Management assigned an A-2 rating to the equipment needed by research laboratories.

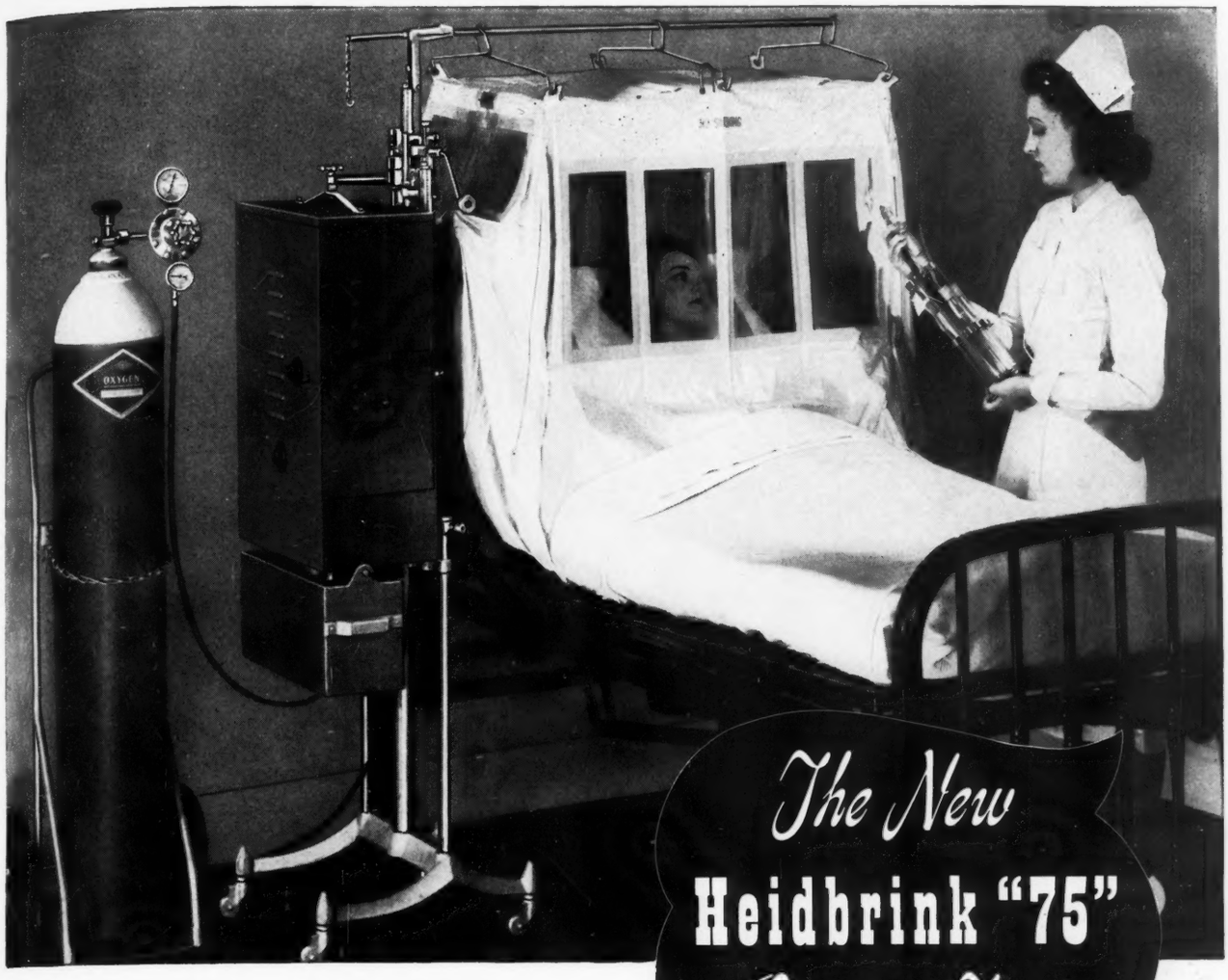
According to the announcement from O.P.M., there are in the United States some 2000 research laboratories that use small quantities of about 5000 chemicals and require 25,000 different instruments in their operation.

As the O.P.M. defines it, "scientific research" includes both industrial and medical research.

Applications for priority under this scientific research rating plan will be referred to the American Academy of Science for its recommendations.

Residence Will Become Nurses' Home

The Royal Victoria Hospital, Montreal, Quebec, has been presented with a large residence to be converted into a nurses' home, the gift of Lady Meredith. According to Dr. G. F. Stephens, superintendent, the gift will meet a great need of the hospital, as accommodations for nurses have been inadequate. The mansion will house approximately 30 nurses, Doctor Stephens said.



The New Heidbrink "75" Oxygen Tent

The new Heidbrink "75" Oxygen Tent embodies the most recent advances in Oxygen tent design. Its many new features provide better control through a wider range of cooling within the tent hood than heretofore has been obtainable and greater efficiency of the soda lime in removing Carbon Dioxide from the air within the tent.

The features of both motor and injector types of tent are combined in one compact unit that meets the demands of the most exacting therapist. With the Model "75" the operator may use either the injector or the motor blower individually, or may combine both to provide greater circulation and cooling. The desired temperature within the hood is rapidly obtained and can be maintained as set.

Any nurse can easily perform every duty incident to the movement, adjustment, mechanical operation and practical application of the Heidbrink "75". Adjustment to bed height is accomplished by an elevating mechanism that operates easily and quickly.

To add to its flexibility, Model "75" provides for the use of cracked ice, FlakIce, or dry ice. The last two require accessory equipment at small additional cost.

Model "75" can be quickly lowered and the tent arm folded for easy storage. For detailed description of Heidbrink "75" Oxygen Tent, mail the coupon below.

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Please send complete details and specifications of the Heidbrink "75" Oxygen Tent.

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Just an Army Game

Reprinted from Wichita, Kan., Eagle, August 20

Prochazka-to-Scuka-to-Pohlman-to-Mayes-to-Pohlman.

No, that's not a quadruple play at the national tournament nor a lateral pass series in a gridiron game. It's the latest stage of the county's "find the doctor" game at the county hospital.

The game started early this year when Dr. Otto Prochazka was named superintendent of the (Sedgwick County) hospital. Doctor Prochazka was just getting well warmed up on the job when the long arm of Uncle Sam reached out, plucked his name from the reserve officers' list and ordered him forthwith to active duty at Camp Robinson, Ark.

Next superintendent was Dr. Clayton Scuka. Doctor Scuka lasted a few weeks when along came Uncle Sam again. Doctor Scuka went to the Army, so the county board and the Sedgwick County Medical Society went into another huddle and the upshot was that Dr. John F. Pohlman, native Wichitan, was named superintendent.

Doctor Pohlman never had a chance even to warm the superintendent's chair at the county hospital. Less than a week after the appointment was made and before the doctor had moved his effects into the county hospital, Uncle Sam stepped in again. Doctor Pohlman went on active duty with the Army.

The county board was hanging on the ropes, and so was the medical society. They entered into one last despairing huddle and the upshot was that Dr. R. H. Mayes, who did not hold a reserve commission, was appointed superintendent. All breathed a sigh of relief; since the doctor wasn't a reserve officer Uncle Sam couldn't upset the applecart this time.

They learned, this week, that Uncle Sam had a final joker up his sleeve.

Doctor Pohlman was released from active duty because of a minor physical defect. Under regulations as laid down by Uncle Sam, any person taken from his job for Army duty is entitled to have that job back when released from the Army.

So, Tuesday the county board and the medical society agreed that the only thing under the circumstances was to restore Doctor Pohlman to the post of superintendent. Doctor Mayes will return to the position of resident physician which he occupied prior to Dr. Pohlman's Army duty summons.

Plan Special Mobilization for Physicians and Dentists

Following a recommendation made some time ago by the American Medical Association, Federal Security Administrator Paul V. McNutt announced on August 29 that a single recruitment and assignment agency would be set up in cooperation with the Army, the Navy and the Public Health Service to administer the mobilization of medical and dental personnel.

"The major principle of the plans, which recognizes the need for a systematic approach to the mobilization of the medical resources of the country," Mr. McNutt said, "has the full sanction of the American Medical Association, as well as that of the health and medical committee of my office and steps are being taken through appropriate channels to obtain necessary enabling legislation."

Mr. McNutt pointed out that already the demands for physicians and dentists imposed by the needs of the Army, Navy and defense industries are seriously draining many communities of their medical personnel.

Hospital Lien Law Passed

The Missouri Hospital Lien Law bill has been signed by Governor Forrest C. Donnell and will become effective October 10.

Texas Hospital Service Adopts Recommendations to Gain A.H.A. Approval

Group Hospital Service, Inc., of Texas recently took steps to qualify for approval by the American Hospital Association. On July 1, 90,000 persons had enrolled.

Recently, the board of the plan and individuals who were instrumental in the organization and operation of single hospital plans in Dallas undertook a study of the affairs of Group Hospital Service. Edward Groner, executive director of the Hospital Service Association of New Orleans, and Ray F. McCarthy, executive director of Group Hospital Service, Inc., St. Louis, were invited to survey the plan.

The following recommendations for reorganization were adopted by the board of the plan and the action was concurred in by the trustees of the Texas Hospital Association:

1. The hospital's contract should guarantee the provision of service to subscribers.

2. Hospitals should be paid on a per diem rather than on a fee-for-service basis.

3. Subscriptions of certain individually enrolled participants and other individuals who were accepted through unorganized groups should be canceled.

4. Subscriber contracts should be revised to provide service benefits instead of cash indemnities.

5. The accumulated deficit should be assumed by the contracting hospitals and carried on the books of the corporation as a contingent liability repayable from earned surplus.

6. The administrative office of the plan should be reorganized to establish certain controls necessary to the intelligent understanding of the operation of the plan.

7. A general educational program should be conducted to emphasize the public character and the community interest in the hospital plan as opposed to the present understanding of it as "another insurance company."

8. An executive director should be appointed.

Hospital superintendents and trustees representing hospitals with a majority of the beds in all participating hospitals voted to recommend cooperation in the contemplated program so that the plan might conform with the standards of the American Hospital Association for hospital service plans.

Walter R. McBee, formerly director of Group Hospital Service, Tulsa, Okla., was unanimously elected executive director of Group Hospital Service, Inc., and assumed his duties last month.

Large Increase Shown in Enrollments of New York City Schools of Nursing

New York City's campaign to forestall the shortage of nurses by expanding its training program is making headway, Dr. Willard C. Rappleye, commissioner of the department of hospitals, reports, with an increase of almost 50 per cent in the enrollment in schools of nursing. The total number of new students admitted for the fall term in New York's training schools was 373 as compared with 254 last year.

Total enrollment in the city's training schools is as follows: Bellevue, 348; Mills Training School for Men, 68; Cumberland, 88; Harlem, 128; Kings County, 599; Metropolitan, 176; Fordham, 40. All students accepted are required to pass rigid entrance requirements of health, general ability, character and personality.

An innovation at the New York Medical College, Flower and Fifth Avenue Hospitals is the plan for two classes for student nurses, the first of which was in session on September 8 with an enrollment of 30. The second group is expected to start classes in March with an enrollment of 35 students, bringing the total number of nurses enrolled in the school to 120.

M. BURNEICE LARSON, DIRECTOR

Is there any factor in the world of hospitals quite so important as high professional standards? You who have struggled to gain recognition for an institution—who have devoted years to meeting the rigid requirements of national professional organizations—will readily answer in the negative.

Because of the nation's need for highly trained people to fill medical, nursing and laboratory appointments, many desirable positions have been left open in the leading hospitals of the country, in clinic groups, large industries, public health organizations, the offices of physicians in private practice. Hospital administrators and other executives are earnestly seeking men and women able to take over heavy responsibilities in nearly all departments.

If you are academically and professionally prepared to undertake responsibility in some phase of hospital service, or in the medical profession, please let us know at once. We can, at this time, assist you in making more rapid professional progress than would be possible in ordinary times . . . provided your qualifications meet the requirements outlined for approved institutions.

Our registration form will cover the information we should have concerning your preparation and plans in order to refer opportunities of importance to you. Your name, address, and a brief statement of your principal interest will bring the proper registration form to you. Our service is nationwide,—it is confidential. May we tell you more about it?

The MEDICAL BUREAU

PALMOLIVE BUILDING **CHICAGO**

Our booth at the Congress of American College of Surgeons in Boston, November 3-7, will be Number 119.

Medical Service Plan Bases Individual Fees on Subscriber's Income

A new medical service plan for New York City and 12 near-by counties was announced last month. This plan will use a sliding scale of fees, based on the income of the subscriber. For single persons earning less than $75 per month the fee is 75 cents per month. With incomes of from $76 to $100 per month the fee is 90 cents; for those with incomes of from $101 to $125 the charge is $1.05 and for those with incomes over $125 the rate is $1.25.

For persons with dependents the scale is as follows: up to $100 income per month, 75 cents; from $100 to $140 income, 90 cents; from $141 to $175 per month, $1.05, and for incomes of more than $175 per month the fee is $1.25.

The subscriber will be limited to a total reimbursement for general medical service of $300 in any one year and a similar amount for surgical fees. However, the grand total payment on behalf of any one subscriber shall not exceed $500. Also, the initial small payment on an illness is not covered. This is set at $5, $7.50 or $10, according to the income bracket.

It is stated that almost 2500 physicians have enrolled in the plan. This is the third such plan licensed in New York City and there are also medical indemnity plans in Buffalo and Utica.

Coming Meetings

Oct. 2—Manitoba Hospital Association, Winnipeg, Man.
Oct. 8-10—Ontario Hospital Association, Royal York, Toronto.
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.
Oct. 20-23—American Dietetic Association, Hotel Jefferson, St. Louis.
Oct. 20-31—New York Institute for Hospital Administrators, New York City.
Oct. 23-24—Missouri Hospital Association, St. Louis.
Oct. 24—Idaho Hospital Association, St. Joseph's Hospital, Lewiston.
Oct. 24—Maryland-District of Columbia Hospital Association, Hotel Belvedere, Baltimore.
Oct.—Saskatchewan Hospital Association, Moose Jaw, Sask.
Oct.—British Columbia Hospital Association, Empress Hotel, Victoria.
Nov. 3-6—Hospital Standardization Conference, American College of Surgeons, Statler and Copley-Plaza hotels, Boston.
Nov. 3-7—American Association of Medical Record Librarians, Hotel Westminster, Boston.
Nov. 8-9—Association of California Hospitals, Hotel Californian, Fresno, Calif.
Nov. 10—Association of Western Hospitals, Public Hospitals Section, Fresno, Calif.
Nov. 12-13—Kansas Hospital Association, Topeka.
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.
Nov.17-28—Southwestern Institute for Hospital Administrators, Southern Methodist University, Dallas, Tex.
Dec. 4—Utah Hospital Association, Salt Lake City.
Jan. 1942—Wisconsin Hospital Association, Hotel Schroeder, Milwaukee.
Feb. 26-28, 1942—Texas Hospital Association, Houston.
March 11-13, 1942—New England Hospital Assembly, Hotel Statler, Boston.
April 6-10, 1942—American Congress on Obstetrics and Gynecology, St. Louis.
April 9-11, 1942—Southern Hospital Conference, Peabody Hotel, Memphis, Tenn.
April 13-16, 1942—Association of Western Hospitals. Olympia Hotel, Seattle, Wash.
April 23-24—Mid-West Hospital Association, Hotel Continental, Kansas City, Mo.
April 27-29, 1942—Iowa Hospital Association, Fort Des Moines Hotel, Des Moines, Iowa.
June 8-12, 1942—American Medical Association, Atlantic City, N. J.
August, 1942—Western Institute for Hospital Administrators, Stanford University, Calif.

Administrators' Institute to Be Held in New York City

The New York Institute for Hospital Administrators, conducted by the American College of Hospital Administrators in cooperation with the faculty of Cornell University Medical College and the hospital associations of seven Eastern states, will be held at Cornell University Medical College, New York City, October 20 through 31.

The curriculum for the institute includes lectures, group conferences and field trips. Current problems created by the defense program will receive special consideration, according to advance literature recently released.

The Newer Concepts of Meat in Nutrition

Meat . . .

and the Dietary in Arteriosclerosis, Hypertension, and Cardiac Disease

THE thought that recovery from many morbid states is retarded when nutritional requirements are not adequately satisfied is gaining increasing acceptance. The burden of disease processes imposes new demands upon the organism, some of which frequently are of a nutritional nature.

While nutritional requirements may not be increased in arteriosclerosis, hypertension, and cardiac disease, they nevertheless must be met. The older practice of interdicting protein foods is now known to be erroneous, since the effects of protein deficiency may aggravate cardiac and vascular disease. Edema due to hypoproteinemia adds to the load of an already overtaxed myocardium. In coexisting chronic nephritis with albuminuria (nephrosis), the protein intake must be increased in order to make up for that lost with the urine. Furthermore, reliable evidence attests that protein in daily amounts of 1 to 1½ grams per kilogram of body weight does not unfavorably influence the clinical course of arteriosclerosis, hypertension, and cardiac disease.

Meat, an excellent source of proteins of high biologic value, has a recognized place in the dietaries of cardiac and vascular affections. Its high coefficient of digestibility is a valuable feature when small feedings are required, and its appeal to the palate is an aid in tempting the usually lagging appetite. Moreover, meat provides thiamine, riboflavin, and nicotinic acid in significant amounts, as well as iron, phosphorus, and copper, and thus contributes to the daily requirements of these important vitamins and minerals.

White, P. D.: Heart Disease, ed. 2, New York: The Macmillan Company, 1937.

Fenn, G. K.: Cardiovascular Disease in the Aged, M. Clin. North America 24:23 (Jan.) 1940.

Jolliffe, N., and Rosenblum, L. A.: Circulatory Manifestations of Vitamin Deficiency: Diagnosis, Treatment, and Prevention, M. Clin. North America 23:759 (May) 1939.

The Seal of Acceptance denotes that the statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

American Meat Institute

CHICAGO

Names in the News

Administrators

Homer C. Harris has succeeded Mae Fye as superintendent of Municipal Hospital, Virginia, Minn.

Dr. E. J. Rennell temporarily is taking over the position of superintendent of Pontiac State Hospital, Pontiac, Mich., during the absence of Dr. P. V. Wagley. Doctor Wagley has been called into active service as a member of the Army Medical Corps.

Dorothy Garrigus King, R.N., has resigned her position as superintendent of Methodist Hospital, Princeton, Ind., and has taken over the superintendency of Broward General Hospital, Fort Lauderdale, Fla.

Mrs. Walter Phelps Warren has been named superintendent of Samaritan Hospital, Troy, N. Y., succeeding Grace E. Allison, who will retire.

John Van Metre is serving his administrative internship under the direction of Dr. Lucius Wilson at the Hospital of the Protestant Episcopal Church, Philadelphia.

Sister Mary Redempta has been appointed superintendent of Mercy Hospital, Chicago, to succeed Sister Mary Lidwina who has occupied the combined post of superior and superintendent since 1935.

Mollie Bowman, R.N., has assumed her new duties as administrator of Susan B. Allen Memorial Hospital, Eldorado, Kan., replacing Teresa Lorenz.

Mrs. Myrtle C. Park has resigned as superintendent of Community Hospital, Berea, Ohio.

John C. Rathbun has been succeeded by Whitlow H. Hunt as superintendent of Maple Avenue Hospital, DuBois, Pa.

Wynona J. Blackburn has been elected superintendent of Bryan Memorial Hospital, Lincoln, Neb. Miss Blackburn succeeds Myrtle Dean who has been head of the hospital since it was opened fifteen years ago.

Fleeta Johnson has been transferred to Weedn Hospital, Marlow, Okla., replacing Mabel Almon as superintendent of the hospital.

Mabel Silvis, superintendent of Henry Clay Frick Memorial Hospital, Mount Pleasant, Pa., for the last thirteen years, has announced her resignation.

Donald M. Rosenberger has resigned his post as superintendent of the Clearfield Hospital, Clearfield, Pa., to become superintendent of the Hamot Hospital in Erie, Pa., filling the post left vacant by the death of Col. Percy L. Jones.

Richard O. West has been named administrative intern at New Haven Hospital, New Haven, Conn.

Dr. Herbert T. Wagner, administrator of Stuart Circle Hospital, Richmond, Va., was elected president of the Richmond Hospital Council recently.

Kingsley W. Eckert, a graduate of the course in hospital administration of the University of Chicago, recently was appointed administrator of the Pulaski Hospital, Pulaski, Va.

James Dack is serving his administrative internship at Butterworth Hospital, Grand Rapids, Mich.

Keith O. Taylor has been appointed administrative intern at Alameda County Institutions, Oakland, Calif.

Department Heads

Pauline Hughes has been appointed director of nursing and nursing education at the Sanitarium of Paris, Paris, Tex., filling the post left vacant by the death of Agnes Hogg. Miss Hughes has been superintendent of nurses at the Gainesville Sanitarium, Gainesville, Tex., for thirteen years.

Lulu E. Ferris, formerly connected with Flushing Hospital, Flushing, L. I., has taken over her duties as superintendent of nurses and principal of the school

Patients enjoy these fine toilet soaps as much as we nurses do!

PALMOLIVE is now used in more homes than any other toilet soap. Made with rich Olive and Palm Oils, its gentle, cleansing lather has made it the world's favorite toilet soap!

COLGATE'S FLOATING SOAP is pure, white and unsurpassed in quality. It produces abundant lather in either hot or cold water. Gentle and fragrant, it's a soap patients will appreciate.

CASHMERE BOUQUET'S rich, creamy lather, and delicate, lingering fragrance have made it a prime favorite with women for generations. It leaves them feeling refreshed, dainty . . . long after bathing.

INCREASED attention is being paid to the "little things" that make hospitalization easier, less grim—even such things as the selection of soaps for patient care. This is reflected in the increased demand for Colgate-Palmolive-Peet soaps, notably Palmolive, Cashmere Bouquet and Colgate's Floating Soap.

These three fine soaps meet the highest hospital standards. They enjoy an enviable popularity in the homes of the entire country. And, because of the volume in which they are produced, they are priced to meet the tightest budget. Ask your C.P.P. man for prices on the sizes you need. Or, write to us direct.

COLGATE-PALMOLIVE-PEET CO.

INDUSTRIAL DEPARTMENT . . . JERSEY CITY, N. J.

of nursing at White Cross Hospital, Columbus, Ohio.

Mrs. Charlotte Dowler, after a year's study of hospital administration at the University of Chicago, has returned to her position as director of nurses at St. Luke's Hospital, Spokane, Wash.

Mary M. Maxwell, executive secretary of the American Association of Medical Social Workers, has resigned to accept the position of director of the social service department of the University of Iowa Hospitals, Iowa City, Iowa. Miss Maxwell will assume her new duties on October 1.

Miscellaneous

Anna B. Nicholson, R.N., surgical supervisor at Hudson City Hospital, Hudson, N. Y., has retired from active hospital work.

Dr. L. Stolfa has been appointed medical superintendent of Yuba County Hospital, Marysville, Calif., to succeed Dr. E. R. Burnight, who has been called for service in the Army Medical Corps.

Dr. T. L. Foster, formerly superintendent of the Osawatomie State Hospital, Osawatomie, Kan., has assumed his new duties as a staff member of the Hertzler Clinic, Halstead, Kan.

Dr. Charles W. Knapp, chief of staff at Greenwich Hospital, Greenwich, Conn., has resigned. His place will be taken by Dr. John A. McCreery.

Frances Stevenson, instructor at Axtell Christian Hospital, Newton, Kan., has been named assistant nursing arts instructor at Grace Hospital, Detroit. Amy Aslam, R.N., succeeds Miss Stevenson at Axtell Christian Hospital.

Dr. Jacob Prager has resigned as medical director of Mount Sinai Hospital, Philadelphia, to enter private practice.

Dr. Margaret B. DuBois has been named a field representative of the American College of Surgeons. Doctor DuBois is the first woman to occupy such a position.

Deaths

Stephen Wierzbicki, superintendent of the Wills Eye Hospital, Philadelphia, since 1923, died at the hospital August 27.

Karl Eilers, president of the Lenox Hill Hospital, New York City, for fourteen years and first president of the Associated Hospital Service of New York, died at the age of 75. Mr. Eilers was succeeded in his post as head of the Associated Hospital Service by Dr. S. S. Goldwater, former commissioner of hospitals.

Dr. Morgon John Rhees, director of Joseph H. Pratt Diagnostic Hospital, Boston, died suddenly on August 25.

Dr. Arthur Roosevelt Bowles, former acting director of Grasslands Hospital, Valhalla, N. Y., died in Indianapolis on September 3.

Col. Percy L. Jones, director of Hamot Hospital, Erie, Pa., died on August 13.

C. H. Schweppe, President of St. Luke's Hospital, Dies

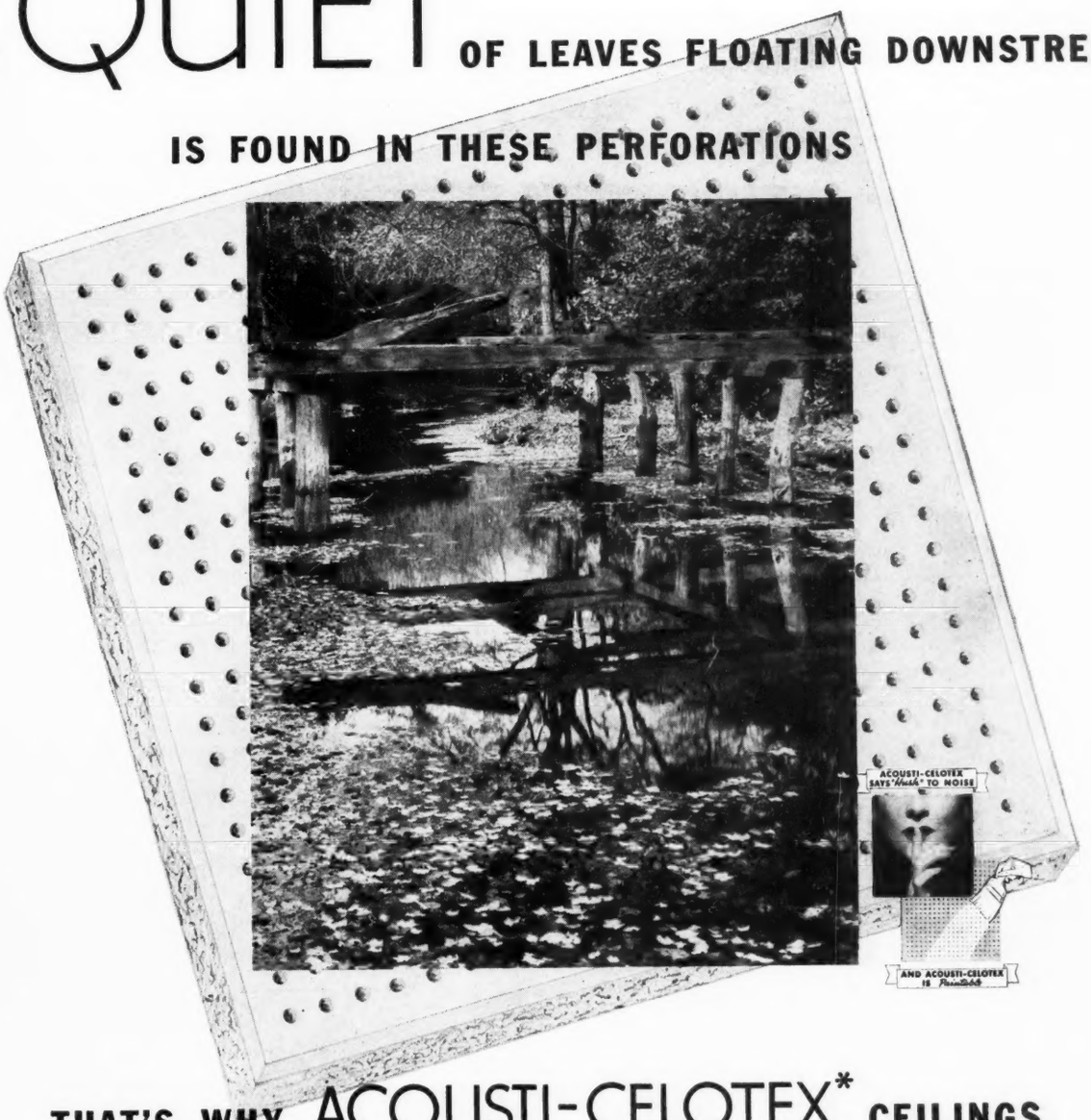
The hospital world was shocked by the death on August 26 of Charles H. Schweppe. Mr. Schweppe had been president of the board of trustees of St. Luke's Hospital, Chicago, for sixteen years and president of the Chicago Hospital Council from the time of its formation until a year ago. He was one of the original incorporators of the Plan for Hospital Care and had been its treasurer since its formation.

Since 1938 Mr. Schweppe had headed the state board of public welfare in Illinois. He was president of Lee Higginson Corporation, investment bankers, and a director of Marshall Field & Co. and Fairbanks, Morse Company. He was 60 years old. A gun was found near him and a coroner's jury decided that Mr. Schweppe had committed suicide while in ill health.

Associates reported that Mr. Schweppe devoted as much time to his interests in St. Luke's as to his own business.

THE QUIET OF LEAVES FLOATING DOWNSTREAM

IS FOUND IN THESE PERFORATIONS



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DOCTORS say that when a patient is definitely on the road to recovery, plenty of sleep is a big help. And doctors, nurses, and patients unite in praising the QUIET achieved by Acousti-Celotex* ceilings—*an important contributing factor in inducing restful sleep.* Corridors, wards, nurses' bays, lobbies, dining rooms, and nurseries—all need this modern sound-quieting method!

Let Celotex acoustical experts make a FREE Noise Survey of your hospital and show you, without obligation, how inexpensively Acousti-Celotex may be applied to old or new ceilings. They will gladly point out why its acoustical efficiency *continues unimpaired through repeated painting or cleaning*—a vitally-important sanitary consideration in hospitals. Write today for full details.

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Intern and Nurse Shortage Is Acute, Dr. Winford Smith Says

(*Continued from page* 73)

trained on the job or in six to eight month courses, was recommended. The use of unpaid volunteer nursing aids, as recommended by Mayor LaGuardia's Office of Civilian Defense, can be advantageous but only if the aids are enrolled for definite service with specified hours, serving definite days each week, Doctor Smith asserted.

As the demands for graduate nurses increase, however, they cannot be met unless more of the graduates are willing to give up, at least for the period of the emergency, the larger financial return from private duty, he stated, and added that present indications do not promise that the nursing profession will do this.

Second only to the need for more graduate nurses is the need for more student nurses. Doctor Smith called for an increase of at least 15 per cent in enrollment for the full training period and for public encouragement by governmental authorities for this increase. The need for more teachers and a competent staff of graduates for supervision and general duty should stimulate the military hospitals to try to use aids and attendants to ease somewhat the demand for graduates. Such aids can be trained in civil hospitals, Doctor Smith stated.

The speaker urged that the regular course of training should not be shortened except as a last resort. "The need of more thoroughly trained and competent nurses with good educational background is real even now and will be just as real, perhaps even greater, after the emergency."

How Cambridge Hospital Has Planned for Defense Emergency

A 1000 ton coal pile in a hospital backyard may seem like an odd feature of the landscape. But Dr. A. G. Engelbach, director, Cambridge Hospital, Cambridge, Mass., sleeps better at night because of this and other preparations for disaster or emergency. Meantime, the price of the coal has gone up.

This is one of the many defense and emergency preparations that have been taken at Cambridge Hospital. A survey disclosed locations found for 100 additional beds, most of which have been obtained, put in operating order and stored in the attic of the nurses' home. Other equipment and supplies necessary to care for such an emergency load have also been provided.

Two years ago the hospital bought surgical instruments for a three year period; this supply is at the present time two thirds exhausted.

The community facilities for emergency hospitalization have been surveyed and plans made for placing up to 250 additional beds in service, whenever required.

The hospital has electric service from a utility company that is connected with five other independent generating companies. An additional connection to another company was also run into the hospital. Also kerosene lanterns, supplies of kerosene and tallow candles have been provided in the hospital.

A new water supply line that is fed from a different reservoir, an increase in linen supplies and an expanded nursing school program are also in operation as a part of the emergency plan.

SOME ARMY FOOD FACTS

Mary I. Barber, food consultant to the Secretary of War, told the A.H.A. convention a few facts about the Army's food budget:

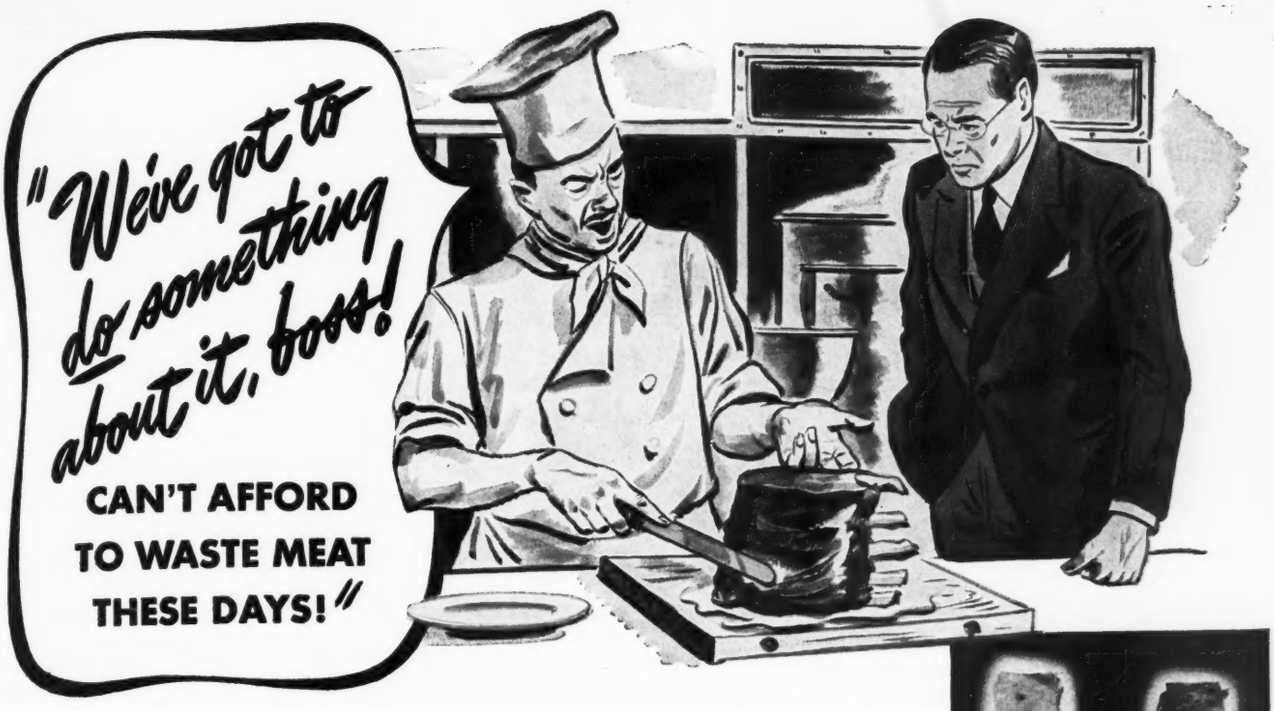
The daily food expense is $630,000.

Beef is consumed at the rate of one every 54 seconds night and day.

In the state of Louisiana alone, 280,000 loaves of bread come out of field ovens every twenty-four hours.

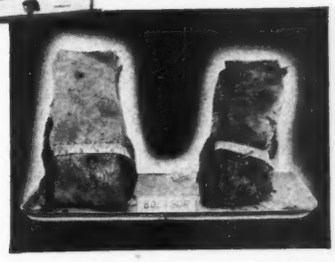
More than a million ½ pint bottles of milk are purchased daily.

Egg consumption is 1,500,000 a day.



TESTS SHOW SHRINKAGE LOSSES OF 36¢ to 56¢ IN COOKED MEAT ON EVERY RIB OF BEEF

Well-done meat losses, often as high as 45%, were reduced to 14% in a test described* by Miss K. Vaughn, prominent restaurant operator. Other tests showed savings of 18% to 20%—still a loss of 36¢ to 56¢ worth of cooked meat on every rib of beef and important because that loss can be kept as low as 8% on ribs cooked rare. Stop waste, and—



"A basic need in any form of modern cookery is the greatest possible elimination of guesswork," says Miss K. Vaughn. A roasting thermometer, to show degree of doneness, and modern thermostatic oven heat control can save hundreds of dollars every year, now going up the flue in the form of smoke.

MEET RISING FOOD COSTS WITH MODERN COOKING EQUIPMENT!

Miss Vaughn says, "Any kitchen operator can do big things in bringing meat shrinkage to a minimum, in avoiding the waste of overcooking, in speeding the cooking process, and in turning out the type of product which will make for maximum customer-satisfaction!"

How? By using a dependable meat thermometer, and by installing modern insulated ranges with thermostatic control. The new Vulcan 50th Anniversary Line of streamline cooking equipment embodies every practical improvement for saving gas and improving service. It represents more than 50 years experience in outfitting commercial kitchens. Before you buy *any* equipment, see Vulcan!

New Vulcan Double-Decker Oven gives practically double the working space with no increase in gas consumption. Heavily insulated. Automatic heat control.

*THERE IS NO PROFIT IN SMOKE—*American Restaurant Magazine,* April 1941

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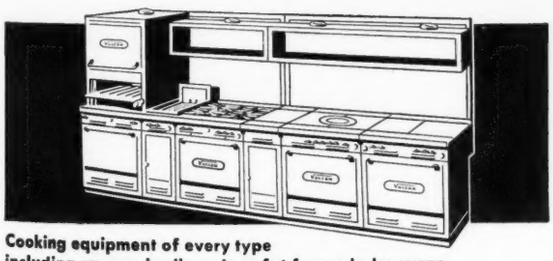

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Resolutions That Urge High Supplies Rating Are Adopted

(*Continued from page 65*)

list. Until Mr. Nelson approves the list, however, it cannot be released.

Although the delegates asked for good priorities for the needed supplies and equipment, the assembly adopted a resolution proposed by the purchasing agents' breakfast meeting that pledged hospitals to separate needs from wants, to conserve supplies and equipment, to eliminate waste, not to build up inventories beyond indicated needs and to give full cooperation in the national interests during the present emergency.

Milton H. Luce, administrator of the Health Supplies Rating Plan, told hospitals that every effort would be made to give them all of the materials that they really need but that they would have to cooperate by avoiding unnecessary consumption. Luxury items and postponable consumption must be eliminated, he said.

Applications from manufacturers of the 14 classifications of health supplies, which were included in the original list announced by the Office of Production Management, have been pouring in at the rate of about 150 a day, according to Mr. Luce. Some of the correspondence indicates a misunderstanding on the part of many distributors and some hospitals, who have mistakenly applied for ratings for themselves. Under the plan, priority ratings are to be given only to manufacturers.

Ways of Meeting Intern Shortage

Hospitals which, because of the intern shortage, plan to permit nurses to perform certain procedures ordinarily performed by doctors only should have the request come from the medical staff and be approved by the board of trustees, it was the consensus of opinion at the intern and resident section. The nurses who perform these procedures should be especially selected and trained.

The dictaphone is apparently to play a leading rôle in the current hospital emergency caused by the shortage of interns and nurses. Interns are to be used for medical duties only; nurses cannot be spared to take over the clerical duties formerly performed by the interns, such as recording histories and physical examinations. So this mechanical aid will be called upon to relieve the pressure.

Speakers and panel discussants at the intern and resident section expressed surprise when a show of hands indicated that 31 small hospitals represented at the session use salaried house officers to perform the duties assigned to interns and residents in the larger hospitals.

This new solution to the small hospital's problem is the logical one, it is agreed, but leaders in graduate medical education feared at this time of emergency it would be difficult for hospitals to find men for this post.

The salaried house officer can do the work of three interns, the panel agreed, and the salary paid him should be between $100 and $150 and maintenance.

Representatives of the Intern Council of America attended the session and participated in the discussion.

Volunteers Contribute to Rehabilitation

The volunteer's contribution to the patient's recovery is second only to that of the doctor in the rehabilitation program extensively undertaken at the Country Sanatorium of Montefiore Hospital. The hospital and volunteer group tries to determine what line of work each patient can be trained to enter following his discharge. With volunteer aid classes have been instituted for tuberculous patients in photography, bookkeeping, shorthand and watchmaking.

Books on Review

START TODAY! YOUR GUIDE TO PHYSICAL FITNESS. *By C. Ward Crampton, M.D. New York City: A. S. Barnes and Company.* 1941. *Pp.* 224. $1.75.

Fortified with a preface by Dr. Alexis Carrel, an editorial quotation from Dr. Morris Fishbein and a letter of introduction from Secretary Frank Knox, this book, dedicated to Franklin Delano Roosevelt, commander in chief of the Army and Navy of the United States, carries a message that is of special concern to all adults. Doctor Crampton gives pertinent instructions for an effective program for obtaining and maintaining physical fitness.

Corrective exercises beginning in the morning and taking one through the day are charted. Diet management is explained and a guide for health examinations is included. An interesting chapter entitled "Place of Exercise in Life" is extremely worth while and gives advice to people of all ages about doing, overdoing and underdoing.

The book is written in good style and covers the essential facts. It is not a book for the library shelf; it should be circulated freely throughout the hospital.

Administrators will do well to recommend this book to heads of their schools of nursing and of allied educational activities carried on within the hospital. —ROY AMBERG.

ELGIN PAPERS. COLLECTED AND CONTRIBUTED. *Editor, Charles F. Read, M.D. Published with the approval of the Department of Public Welfare, State of Illinois.* 1941. *Pp* 285.

Dr. Charles F. Read, managing officer of the Elgin State Hospital, Elgin, Ill., can justly point with pride to the research of his staff as embodied in this volume, the fourth of a series published during the past few years.

Most of the contributions have already been published in psychiatric or other medical journals, indicating their scientific acceptability, but those papers published for the first time have merit as well as interest. A wide range of topics is covered, with a preponderance of papers on the newer forms of shock therapy; each of them is worth reading despite the occasional criticism that might be raised concerning the manner of experimental procedure, paucity of data or somewhat awkward literary style.

The general hospital administrator will be interested in the final pages in which a résumé of the extensive teaching and research program at Elgin State Hospital is presented.

Of special interest to the reviewer is the small statistical table at the very end of the volume in which the movement of population for the research biennium is described. These data are of importance since one can compare them with data from other hospitals in which there is no research program. It may not be accidental that of 2729 patients discharged from Elgin 951 were "without psychosis," 1722 had recovered or improved and only 56 were unimproved. This is an astonishing record.

On the other hand, of the 1974 patients who were paroled, 737 were returned within this period, a rate of 37 per cent. One wonders whether a more unified research program, rather than the broad one indicated by the various contributions in this volume, might yield fruitful results in the reduction of so high a reinstitutionalization rate. Still the fact remains that it is only by research in state hospitals that such results will eventually be achieved and the Elgin series seems to be concrete evidence of meaningful attempts in this direction. —WILLIAM A. BRYAN, M.D.

After Fifteen Years

(*Continued from page 57*)

Fifteen years ago the average hospital association did not even have a legislative committee; or, if it did, the committee had nothing to do.

I cannot recall any law being passed in that time that has actually improved the care of patients.

* * *

No matter how delicious hospital food may be, there will always be workers who complain. They have that right. And you want them to feel at home, don't you?

* * *

Americans are apparently permitted to lie about two subjects: (1) Junior's age on the street car and (2) family income in the hospital admitting office.

* * *

Chinese laundrymen often receive complaints from hospital administrators about their shirts.

The same administrators operate laundries that clean nurses' uniforms.

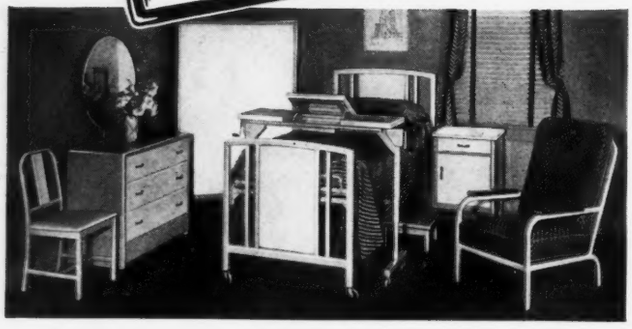
The Chinamen could get a good laugh out of what the administrators have to listen to.

* * *

There are many changes ahead, I am sure. I think the voluntary system, somewhat modified, will persist. I hope so, as I do not think that the American people or American doctors would care for any other kind.

And I still say it is the most interesting work there is.

A Reminder!



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